Pediatric Physicians, Inc.

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the USE & DISCLOSURE of any and all medical records (including but not limited to records of any substance abuse, psychiatric/mental health information or HIV/AIDS information) of:

Patient Name: _____ Date of Birth: _____

Person/Organization Authorized to RECEIVE information:

_____

_____

_____

_____

Practice/Organization/Person(s) SENDING information:

_____

_____

For the following dates of treatment:

_____

_____

For the purpose of: (optional)

— Further medical care
— Insurance/Billing
— Legal Reasons
— Other (please specify)

_____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed to a third party and no longer protected by these regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment or healthcare operations. I may inspect or copy any information used/disclosed under this authorization. This authorization and request is fully understood and is made voluntarily on my part. I release the above-named facility of any legal liability that may arise from the release of the information requested.

Patient Signature: _____ Date: _____

Guardian/Legal Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____

I understand that I may revoke this authorization at any time except to the extent that action based on the authorization has been taken. Cancellation of this authorization must be made in writing and sent to the address below:

Pediatric Physicians, Inc.
3643 Ridge Mill Dr.
Hilliard, OH 43026
Phone: 614-771-0200
Fax: 614-771-5267

This authorization is HIPAA compliant.
Eff. Sept 2015