AUTHORIZATON FOR RELEASE OF INFORMATION

I authorize Green Hills Pediatric Associate (GHPA) to use and/or disclose my child's/children's protected health information (PHI) to:

Office/Doctor's Name: _____
Address: _____
City: _____ State: _____ Zip Code:_____
Phone #: _____ Fax #: _____
Email: _____

The information to be included for use and/or disclosure:
(Check one)

_____ Medical record

_____ Portions of the medical record as listed below
(specify date of service, type of service etc.)

_____

The information will be used or disclosed for the following purpose:
(Check one)
_____ Transfer medical record to another physician
_____ At the request of the individual (if no purpose is stated)
_____ Other (please specify) _____

This authorization will expire on _____.
(Expiration date or Defined Event)
Ex. Upon completion of request.

GHPA will ___ will not ____ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from GHPA. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer.

_____ _____
Patient's Name Date of Birth

_____ _____
Signature of Parent/Legal Guardian/ Patient (if 18 or older) Relationship to Patient

_____ _____
Print name of Parent/Legal Guardian/ Patient (if 18 or older) Date

PARENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION