Pediatric Associates of Mount Carmel, Inc.

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize **Pediatric Associates of Mt. Carmel** to use and/or disclose certain protected health information (PHI) about me to:

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This authorization permits **Pediatric Associates of Mt. Carmel** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

____

____.

The information will be used or disclosed for the following purpose: Please circle one of the following:

____. *TRANSFERING* *NOT TRANSFERING*

(If requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on_____________________.

The Practice 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 **Pediatric Associates of Mt. Carmel**. 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 revocation must be submitted in writing to Cheryl Snell, Office Manager.

Signed by:______________________________ ______________________
Signature of Patient or Legal Guardian — Relationship to Patient

______________________________ ______________________
Patient's Name — Date

____________________ __________________________________
Date of Birth — Printed Name of Patient or Legal Guardian

It is the policy of our office to release medical records for care provided in our office only by our physicians. We do not provide copies which may have been forwarded to this office. These should be requested from the original source. **Please allow two weeks for records to reach their destination. There is a $10.00 charge per copy, which must be paid at time of request.**

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