# ABINGTON PEDIATRIC ASSOCIATES, L.L.P.

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.**

| Patient Name: | |
|---|---|
| Patient's Date of Birth: | Patient's SSN: |

**A. Person(s) or Organization(s) authorized to provide the information:**

_____

_____

**B. Person(s) or Organization(s) authorized to receive the information:**

_____

_____

**C. The following information is to be disclosed: (Please check one box for each item.)**

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ☐ | ☐ | physician notes | ☐ | ☐ | psychotherapy reports |
| ☐ | ☐ | lab results/x-ray reports | ☐ | ☐ | sexually transmitted diseases/HIV reports |
| ☐ | ☐ | developmental reports | ☐ | ☐ | drug/alcohol abuse reports |
| ☐ | ☐ | immunizations | ☐ | ☐ | hospital reports |
| ☐ | ☐ | previous physician's notes | ☐ | ☐ | financial/insurance information |
| ☐ | ☐ | other _____ | | | |

**D. Purpose of request:** ☐ camp ☐ school ☐ daycare

☐ other _____

_____

☐ Authorization that above named person (see B above) may have access to any and all medical health information; discussion, treatment of named child

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1) I understand that unless otherwise revoked, this authorization will expire on the following date, event or condition: (If I do not specify an expiration date, event, or condition, this authorization will expire in six months.) _____ (insert date).
2) I understand: that I may **revoke** this authorization at any time by notifying Abington Pediatric Associates, L.L.P. in writing; that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable); that I may **inspect or copy** any information used or disclosed under this agreement; that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

**NOTE:**
You have the right to know: specifically what information you are authorizing for release; the name(s) or other identification of the person(s) or organization(s) authorized to release the information; who is going to use it and what it is going to be used for.

**YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM**