STRATHMOOR PEDIATRICS
AUTHORIZATION FOR THE USE AND/OR
DISCLOSURE OF PROTECTED HEALTH INFORMATION

PHYSICIAN - CLINIC - FACILITY NAME: _____

ADDRESS: _____

RECORDS TO:

ADDRESS: _____

PHONE NUMBER: _____

_____

This form, once signed, will authorize **STRATHMOOR PEDIATRICS, to SEND** certain **Protected Health Information** (PHI). This information will be sent to the above facility under the direction of the signer below. The signer's signature affirms implied custody or guardianship of the specified patient.

PATIENT NAME: _____ BIRTH DATE: _____

I hereby authorize the disclosure and use of the (PHI) as outlined below. Only the information checked is to be disclosed.

- ☐ Immunization Record Only
- ☐ Last Specialist Report
- ☐ All Specialist Reports
- ☐ Hospital Reports
- ☐ Consultation Reports
- ☐ Operative Report
- ☐ Newborn Medical Record
- ☐ Laboratory Report _____
- ☐ X-Ray Report _____
- ☐ Discharge Summary _____
- ☐ Admission Summary _____
- ☐ History & Physical _____
- ☐ Photo/Electronic Data _____
- ☐ **Entire Medical Record**

1. I understand that this information may include information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) infection; treatment for Drug or Alcohol Abuse or misuse; Mental, Behavioral Health, or Psychiatric Care and treatment.
2. The authorized information may be transferred physically, orally, by fax, by mail, or by electronic measures to the facility listed in the above heading. *(Please mark out all that do not apply)*
3. I understand that should this (PHI) be disclosed to an entity that is not required to comply with the federal privacy regulations, and then such information may be re-disclosed, it may no longer be protected.
4. I understand that I have the right to revoke this information at any time. My revocation must be **IN WRITING** and addressed and delivered to **STRATHMOOR PEDIATRICS.** I am aware that my revocation may not be effective to the extent that the persons I have authorized to use/disclose the (PHI) have acted in reliance upon this authorization.
5. Unless otherwise revoked, I understand that this authorization will expire one hundred eighty (180) days from the date of this form or on the following date or event, if explicitly stated: _____
6. I understand that I have the right to inspect and copy my own (PHI), or the (PHI) of my charges covered by this authorization, in accordance with the requirements of the federal privacy protection regulations found under 45 CFR § 164.524
7. I understand that **STRATHMOOR PEDIATRICS** may not condition treatment on the completion of this authorization except as indicated in 45 CFR § 164.508(b)(4). However, failure to disclose information may delay treatment of medical problems.

I certify that I have read and received a copy of this authorization

Signature: _____ Date _____

Print Name: _____ Relationship to Patient: _____

Staff Only: Enter Patient Code - _____

Confidential

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