DANVILLE PEDIATRICS AND PRIMARY CARE, PLLC
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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____
Patient's Name **Date of Birth**

By signing this authorization, I authorize _____
Practice Name to release records
to use and disclose certain protected health information (PHI) about me to:

Name and address of Provider or entity to receive information:	_____ _____ _____

This authorization permits the use and/or disclose of the following 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.):
(Check all appropriate boxes)

☐ Complete medical and immunization records

☐ Healthcare information relating to the following treatment, condition, or dates of treatment:
_____

☐ Other: _____

The information will be used or disclosed for the following purpose:	_____ (If requested by the patient, purpose may be listed as "at the request of the individual.") The purpose(s) is/are provided so that our practice can make an informed decision whether to allow release of the information.

This authorization will expire sixty (60) days from the signature date unless otherwise specified.

_____
{Other Expiration Date or Defined Event}.

I do not have to sign this authorization in order to receive treatment. 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 at the practice which I have authorized to release my records.

_____ _____ _____
Signature of Patient or Legal Guardian Relationship to Patient Date

_____
Print Name of Patient or Legal Guardian

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