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

Patient's Name _____ Date of Birth _____

Address _____ City/ST/Zip _____ Phone _____

By signing this release, I authorize the use and disclosure of my protected health information (PHI):

Information to be released from:

☐ Danville Pediatrics and Primary Care

☐ _____

Information to be released to:

☐ Danville Pediatrics and Primary Care

☐ _____

The following information to be released about me: (Check all appropriate boxes)
(If other, specifically describe the information to be used or disclosed, such as date(s) of services, type of services)

☐ Complete Medical Record ☐ Mental and/or Psychological Health Records ☐ Substance Abuse

☐ Immunization records ☐ Pregnancy or sexually transmitted diseases ☐ School exams and/or excuses

☐ Other: _____

The information will be used or disclosed for the following purpose: (Check all appropriate boxes)

☐ Transfer to another Provider ☐ School, Daycare ☐ Moving out of State

☐ Personal Use/ Request of Patient ☐ Legal ☐ Insurance

☐ Other: _____

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. However, pursuant to KRS 304.17A-555, disclosure of mental health/chemical dependency info may not be used /or shared by the recipient of said information unless specific, written consent for redisclosure is authorized by the person or personal representative of whom it pertains.

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

Print Name of Patient or Legal Guardian _____ Witness _____ Date _____

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.

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