GAHANNA PEDIATRICS
NURTURING WHILE HEALING

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Date of Request_____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize _____ (Releasing Practice Name or Organization) at _____ (address) to use and/or disclose certain protected health information (PHI) about my child/children to _____ (Name of entity to receive this information) at _____ (address). This authorization permits the Practice or Organization to use and/or disclose the following individually identifiable health information about my child/children:

- ☐ Immunization Records
- ☐ X-ray/Imaging studies
- ☐ Lab/Diagnostic Tests
- ☐ Entire medical record
- ☐ Other (identify information to be used or disclosed)

_____

The information will be used or disclosed for the following purpose: _____.
The purpose is provided so that I can make an informed decision whether to allow release of the information.
This authorization will expire in 60 days or _____(date).

Redisclosure. Information used to disclose under this authorization will be given to recipients who may redisclose the information and those later disclosures may not 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:

_____(Practice and address)

Child/Children's Name and D.O.B. _____

_____

_____

Signed by: _____(Parent/Legal Guardian)

Print name: _____

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