

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION/ REQUEST FOR RELEASE OF MEDICAL RECORDS

I authorize the use and sharing of my/my child's protected health information either by telephone or in written form:

Patient name: _____ **Date of Birth:** _____
Patient address and telephone number _____

Parent(s) name: _____

Name, address, and telephone number of physician, facility, school personnel, or other individual to release the requested information to / from:

Dates of care: From _____ To _____

Describe specific requests / results _____

This information will be used / disclosed for the following purposes:

I understand there may be a charge for the *release* of this information to the physician, facility, school personnel, etc. if the request is to provide written documentation or copies of the protected health information.

I understand and agree that this authorization will be valid and in effect until _____ (date). I understand that after that date no more of this information can be used or released unless I sign an updated authorization.

Page 2 / REQUEST FOR RELEASE OF MEDICAL INFORMATION

I understand that I can revoke or cancel this authorization at any time by sending a letter to the privacy officer for Children’s Habilitation Center, PC. If I do this it will prevent any further release after the date it is received. I understand that some information may have already been sent or shared before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional listed above.

I understand that I may inspect and have a copy of the health information described in this authorization. I understand there may be a charge to provide the requested information to me also.

I understand that if the person who receives the information is not a health care provider health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I understand that this professional will receive compensation for the use or disclosure of my health information. The arrangement has been explained and I accept it. Does not apply

I affirm that anything in this form that was not clear to me was explained. I believe that I know and understand all of it.

Signature of patient or guardian **Date**

Printed name of patient or guardian **Date**

I acknowledge that I received a copy of this form.