Norman PEDIATRIC ASSOCIATES

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AUTHORIZATION TO USE OR DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

1. **IDENTIFICATION OF PATIENT AND AUTHORIZATION:** I hereby authorize **(name of previous physician)** _____ **location/phone number** _____to share my protected health information as set forth below for purposes in addition to those already permitted by law. Such information may be released at the request of the individual(s) to whom information may be disclosed, unless another purpose is stated below.

_____
Patient Name Date of Birth

_____
Address City State Zip Phone Number

2. PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

Name	Address	Phone	Fax	E-mail	Purpose of use or disclosure:

3. INFORMATION TO BE DISCLOSED:

_____ Entire Medical Record _____ History/Physical _____ Immunization Record

Other (list): _____

4. **COVERING THESE DATES OF SERVICE** (choose one): 1) between _____ and _____; 2) on (date) _____; 3) _____ All Dates.

5. **EXPIRATION AND REVOCATION**. This Authorization will expire on ____/____/____. I understand that I may revoke this authorization at any time by writing to the address listed above, but that such revocation will not apply to information that has been disclosed pursuant to this Authorization prior to the date upon which such revocation is received. If I do not specify an expiration date, this Authorization will expire 12 months from the date signed below.

6. **ACKNOWLEDGMENT OF UNDERSTANDINGS:** I understand and acknowledge the following:
   a. This Authorization is voluntary and will not affect my eligibility for treatment, payment of claims, enrollment, or eligibility for benefits from Norman Pediatric Associates.
   b. Information disclosed pursuant to this Authorization is subject to being re-disclosed by the person who receives it, and may no longer be protected by privacy regulations.
   c. I may inspect or obtain a copy of the protected health information shared under this Authorization by sending a written request to Norman Pediatric Associates at the address listed above.
   d. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

_____ _____ _____
Signature of Patient, Parent or Legal Guardian Relationship to Patient (if applicable) Date