Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated.

Patients Name **Date Of Birth**

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Entity Requested to Release Information: Pediatric Associates Of Madison

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.
Who will be authorized to receive information (the individual(s) who is to receive your PHI)**:**

_____**Relation**_____

_____**Relation**_____

_____**Relation**_____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the person, or persons identified above:

Entire patient record; **or**, check **only** those items of the record to be disclosed:
___office notes ____lab results, pathology reports ___x-rays
___financial history report (previous 3 years only).

In **Accordance to Alabama State Law**, when a minor reaches the age of fourteen, we cannot discuss the child's private medical information with a parent without the child present or without written consent from the child. The exception is as follows: if a child seeks medical treatment and wishes to use the parent's insurance policy, it is the policy holder's right to know what services their insurance company has been billed for. If the child does not wish for the policy holder to be given that information, they must pay cash up front for that visit.

This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year:_____

You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

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patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.