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Patient Authorization To Use or Disclose Protected Health Information (HIPPA)

I, _____, understand that Healthy Kids Pediatrics is not authorized by me to use or disclose protected health information for a purpose other than treatment, payment or health care operations.

I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner of Healthy Kids Pediatrics or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (check all that apply):

☐ The patient's entire medical record

The patient's demographic information (check all that apply):

☐ Name
☐ Address
☐ State/Zip Code only
☐ Telephone
☐ Age
☐ Gender
☐ Race

☐ Other Medical Data related to :
  ☐ Specific condition(s)
  ☐ Specific professional service(s)
  ☐ Specific medication(s)
☐ Other: _____
_____
_____

Name of person(s) other than myself authorized by this form to use and disclose the protected health information (family members, etc):

_____

_____

I authorize Healthy Kids Pediatrics to contact me by mail, fax or phone regarding information or services that may be helpful or beneficial to me:

_____ _____

Legal Guardian's Name (please print neatly) Legal Guardian's Signature Date