HELPING HANDS PEDIATRICS, INC.

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SHARON, PA 16146
724-346-6494
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Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).
   - __X___ Complete health records
   - __X___ Lab results/X-ray reports
   - __X___ Physical exam
   - _ X____ Consultation reports
   - __X___ Immunization record
   - _____ Other (please specify: COMPLETE MEDICAL RECORDS _____

4. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. *This information may be disclosed to and used by the following individual or organization.*

Name**: HELPING HANDS PEDIATRICS, INC.** _____

Address: **585 E. STATE ST.** _____

City: **_SHARON**_____ State: ____**PA**_____ Zip: **16146**

For the purpose of : **NEW PCP**_____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: Angie Chlpka, Security Officer 724-346-6494.

_____ _____

Signature of patient or legal representative | Signature of witness

Date: _____ Date: _____

Inner Office Use Only: Date Faxed: _____ Initials: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.