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Authorization for Access to Health Information

Name: _____ Date of Birth: _____

Print NAME of individual who's PHI is affected

This authorization gives Concord Pediatrics, PA permission to (please check all that apply):

☐ Provide written PHI to the individual or entity named below.

☐ Obtain written PHI from the individual or entity named below

☐ Exchange PHI verbally with the individual or entity named below

Name: _____

Print NAME of individual or entity with whom you are authorizing Concord Pediatrics to communicate.

Address: _____

Phone Number(s): _____

I understand that authorization for disclosure of this health information is voluntary and I can refuse to sign this authorization. The above-named health care provider cannot condition treatment, payment, enrollment or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Explanation or Revocation of Authorization: I understand that I may revoke this authorization in writing at any time except for health information already shared based upon my authorization.

Without my previous written revocation, this authorization will automatically expire:

☐ One year from the date of my signature or ☐ on _____ (date supplied by signatory)

_____ _____

Signature of Patient or Parent/Guardian Date