Physicians to Children, Inc.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable/protected health information (PHI) as described below. I understand that the information I am authorizing to be disclosed may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations.

Patient's name:_____ Date of Birth:_____

Persons/organizations providing information:_____ Persons/organizations receiving information: _____

_____ _____

_____ _____

_____ _____

Specific description of information to be released/copied including date (s):

_____

_____

_____

Purpose of the use/disclosure: please check ã

( ) Personal copy ( ) Over age 22 ( ) Insurance change ( ) Moving ( ) Doctor closer to home

( ) Going to Family Doctor ( ) Referral to specialist ( ) Other _____

( ) Dissatisfied with Physicians to Children (please state why) _____

The patient, or the patient's representative must read and initial the following statements:

Initial _____ a) I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

Initial _____ b) I understand that I get a copy of this form after I sign it.

Initial _____ c) I understand that this authorization will expire on ___ /___ /_____ or upon the event _____.

Initial _____ d) I understand that I may revoke this authorization at any time by notifying the Privacy Officer at Physicians to Children in writing, but if I do, it will not have any effect on actions Physicians to Children took before it received the revocation.

Initial_____ e) I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the costs of supplies and labor and postage related to the production of my information. I understand that the charge for this service is $.50 per page up to 50 pages; $.25 per page for 51 pages and up.

THE REQUESTED PHI WILL BE RELEASED WITHIN 15 DAYS OF THE RECEIPT OF THIS SIGNED FORM

Signature of patient or representative:_____Date_____

Printed name of patient's representative: _____

Relationship to the Patient _____ Daytime Telephone: _____