Center For Pediatric Medicine *Our Family Caring For Yours*

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Center for Pediatric Medicine, PC to use and/or disclose certain protected health information (PHI) about me/my child to or for the party or parties listed below.

This authorization permits Center for Pediatric Medicine, PC to use or disclose to:

____

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List address, telephone number, *and* person/entity receiving the information

the following individually identifiable health information (specifically describe the information to be released, such as date[s] of service, level of detail to be released, origin of information, etc.):

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When my 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 by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Center for Pediatric Medicine, PC has acted in reliance upon this authorization. My written revocation must be submitted to:
Attn: Matthew Carreira, Privacy Officer, Center for Pediatric Medicine, PC, 107 Newtown Rd, Suite 1D, Danbury, CT 06810.

This expiration will expire on _______________________ (expiration date or defined event).

Signed by: _____________________________________ _______________________________
Signature of Parent/Legal Guardian Relationship to Patient

____ ___________________________
Print Name of Parent/Legal Guardian Today's Date

____
Patient's Full Name

This form must be completed <u>in full</u>. Failure to do so may delay or prevent us from forwarding the requested information.