Authorization for Release of Patient Health Information

Valparaiso Office
Associated Pediatricians, LLC
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Portage, IN 46368
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Patient Name:_____ Patient Date of Birth: _____

Address: _____

City / State / ZIP:_____

Telephone # Area Code first: _____

(for office use only) Medical Account # _____

I hereby authorize the protected health information regarding the above-names person be forwarded:

From:	To: (Recipient)
Person/Institution _____	Person/Institution_____
Address _____	Address _____
City _____	City _____
State / ZIP _____	State / ZIP _____

I authorize the release of information covering the period(s) of healthcare from:
Date(s) _____ To date(s) _____

The type of information to be used or disclosed is as follows:

- ☐ History & Physical examination
- ☐ Consultation reports
- ☐ Progress notes
- ☐ Discharge summary
- ☐ Operative reports
- ☐ Copy of doctor's notes
- ☐ Diagnostic tests (labs x-rays, etc.
- ☐ Immunizations records only
- ☐ Verbal only (please specify)_____
- ☐ Other (Please specify) _____

The following highly confidential items must be checked off to be included in the use or disclosure of other health information:

- ☐ HIV/AIDS related health information and/or records (*the patient 12 or over must authorize this release)*
- ☐ Behavioral or mental health information and/or records (*the patient 12 or over must authorize this release*)
- ☐ Information about sexually transmitted disease (*the patient 12 or over must authorize this release*)
- ☐ Pregnancy (*the patient 12 or over must authorize this release*)
- ☐ Birth control (*the patient 12 or over must authorize this release*)
- ☐ Drug/alcohol diagnosis, treatment, and/or referral information (*the patient 12 or over must authorize this release*)
- ☐ Information about sexual assault/abuse
- ☐ Information child abuse and neglect

This information for which I'm authorizing disclosure will be used for the following purpose:

- ☐ My personal use (there is a fee for personal use copies)
- ☐ Sharing with other health care providers (no charge if sent directly to the provider-address must be provided as recipient above)
- ☐ Other (please specify) _____

This authorization will expire:

Date: _____, 20____ if not otherwise specified this release will expire within 30 days of the date of signatures.

Authorization for Release of Patient Health Information

Patient Name: _____ Patient Date of Birth: _____

Unless revoked, this authorization will expire 30 days from the date of signature on the authorization or from the date noted above. *For mental health purposes this authorization will expire one year from the date of signature.*

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in the Authorization, in which case Associated Pediatricians, LLC may refuse to treat me if I do not sign this Authorization.

I understand that once Associated Pediatricians, LLC discloses my health information to the recipient, Associated Pediatricians, LLC cannot guarantee that the recipient will not re-disclose my health information to a third party. the third party may not be required to abide by this Authorization or applicable federal and Indiana law governing the use and disclosure of my health information.

I understand that I have the 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 Associated Pediatricians, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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.

I have read and understand the terms of the Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Associate Pediatricians, LLC to use or disclose my health information in the manner described above.

Printed Name of Patient or Legal Guardian:

_____

(For information regarding Mental Health, HIV/AIDS, Drug and Alcohol, Sexually transmitted Diseases, Pregnancy and Birth control the patient 12 or over must sign to release those records)

_____

(authorized signature)

If signed by Legal Guardian, relationship to patient: _____ **Date:** _____

For Mental Health Releases Only:

Signature of patient 12 or over: **Witness:**

_____ _____

(Mental health releases must be witnessed)

(Associated Pediatricians, LLC has checked the identification of the signer and ensured that this is the legal representative who has rights of access)