



Modesto Pediatrics

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information

Patient Name (Last, First) & Date of Birth

Address City State Zip

Primary Phone Alternate Phone

Type of Access Requested (Please check ONLY one)

Paper Copy CD Inspection Only

Delivery Method (Please check ONLY one)

Mail Fax Pick-up

Purpose of Requested Use or Disclosure (Tell us how you will use the records)

Transfer of Care Per my request Other: _____

Authorization - I hereby authorize: (Tell us who will be releasing records)

Name of hospital, physician, Healthcare Facility

Address City State Zip

Phone Fax

To Release my health information to: (Tell us who records are going to)

Name of Person, hospital, physician, Healthcare Facility

Address City State Zip

Phone Fax

Information Disclosure (Tell us what information you are requesting)

Information to be disclosed for the following date range (REQUIRED): _____ to: _____

- Clinical Notes
- Outside Records
- Radiology Report(s)
- Laboratory Test(s)
- Billing Records
- Other: _____

Special Authorization (*Initial to give us permission to release the following sensitive information*)

Specifically authorize release of the following information:

- HIV test results _____ (*initial*) Substance abuse _____ (*initial*)
- Behavioral Health _____ (*initial*) Psychiatry _____ (*initial*)

Expiration

This authorization shall become effective immediately and shall remain in effect for one year from the date signed unless a different date is specified here: _____

Restrictions

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPPA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is specifically required or permitted by law.

(This protection does not extend to recipients outside the state of California)

Your Rights

- * I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- * I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to Modesto Pediatrics. My revocation will be effective upon receipt, but will have no impact on uses or disclosure made while my authorization was valid.
- * I have a right to receive a copy of this authorization (required if authorization is requested for the provider's use or disclosure of health information).
- * I may inspect and obtain a copy of the health information of which I am authorizing the use or disclosure of my health information. Copies will be available in **48 hours** for records excluding Behavioral Health Records which can take up to **15 days**.

Signature (*As required by Law*)

SIGNATURE: _____ DATE: _____
(Patient/Legal Representative)

Print Name of Patient: _____ DOB: _____

If signed by anyone other than the patient, print name and relationship:

OFFICE USE ONLY

Verified by (*Print Name, Title, Date*): _____

Verified by (*Signature*): _____

- Photo ID attached Photo ID on file Other: _____