

**PEDIATRIC PROFESSIONAL ASSOCIATES, P.C.**

**PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION TO NON-HEALTHCARE PROVIDERS**

I, \_\_\_\_\_ (custodial parent name) understand Pediatric Professional Associates, P.C. (PPA) is authorized to use or disclose my child's protected health information for a purpose other than treatment, payment, or healthcare operations, to the non-healthcare providers listed below. I understand that I retain the right to revoke this authorization. Please take a few minutes to consider all possible adults who might accompany or contact our office regarding your child, \_\_\_\_\_, DOB \_\_\_\_\_.

Please write full name of all parties that can be notified regarding your child's health information as deemed necessary for appropriate care. Please specify if entire health history is ***NOT*** to be disclosed (i.e. labs only, immunizations only).

**Mother** \_\_\_\_\_  
**Father** \_\_\_\_\_  
**Step-parent** \_\_\_\_\_  
**School nurse** \_\_\_\_\_  
**Day Care Provider/ After School Provider** \_\_\_\_\_  
**Grandparents** \_\_\_\_\_  
**Family Friend** \_\_\_\_\_  
**Neighbor** \_\_\_\_\_  
**Other (i.e. Aunt, Uncle, etc...)** \_\_\_\_\_

My child's parents are divorced. Yes \_\_\_\_\_ No \_\_\_\_\_

This authorization is valid for two years from the date of signature.

All revocations must be sent to PPA to the attention of the Privacy Officer. I fully understand and accept the terms of this authorization.

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**

**For office use only**

Authorization added to patient's medical record on \_\_\_\_\_

Authorization verified by \_\_\_\_\_ on \_\_\_\_\_

Revision: 4/14/03, 6/3/03, 07/17/09, 03/11/10