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 check 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). Please provide names if available:

_____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 one year 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, 11/6/08