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 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, 11/6/08