PATIENT AUTHORIZATION

DISCLOSURE OR RECEIPT OF PROTECTED HEALTH INFORMATION

Name of Patient _____ **Date of Birth** _____

Patient Address _____ **Phone #**_____

_____ **SS#*** _____

*Providing your SS# is voluntary, but necessary to accurately identify your medical records. Failure to provide this information will likely delay the processing of your request.

Approximate Dates of Treatment _____

1) I authorize the following health care provider or facility **TO DISCLOSE** my patient information:
   a) ___ ABC Pediatrics, P.C.

   b) ___ Other: Name: _____Phone:_____

   Address: _____

2) I authorize the following person or organization **TO RECEIVE** my patient information: **Please fax to: 1-801-523-3033**
   a) ___ ABC Pediatrics, P.C 6360 S 3000 E Ste 230 Cottonwood Heights, UT 84121 1-801-523-3030

   b) ___ _____ _____ _____
   Name/Credentials Address Phone

   _____
   Relationship

3) Please disclose the following information: (circle to indicate your selection):

History and Physical	Psychological Evaluation	Discharge Summary	Educational Reports
Treatment Plans	Psychological History	Radiology and Lab Reports	Consultation Reports
Immunizations	Outpatient Clinical Records	Other:_____	

4) Please indicate the purpose of the disclosure of your patient records ____**Transfer of Care**_____
5) If applicable, I understand that based on the dates and information I have designated above, the disclosure ABC Pediatrics, P.C. makes pursuant to this authorization may include information regarding my or my child's participation in a substance abuse treatment program.
6) I understand that is the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations, and the recipient my re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
7) I understand that ABC Pediatrics, P.C. will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.
8) I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: ABC Pediatrics, P.C., 6360 South 3000 E STE 230, Cottonwood Heights UT 84121.

I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires:

a) _X_ One (1) year from the date I sign below ___ One-time disclosure only **(CHECK ONE)**

Patient Name: _____ _____
(PLEASE PRINT) Signature of Patient or Representative **Date**

_____
Name of Personal Representative (if applicable) – PLEASE PRINT

Witness Name: _____ _____
(PLEASE PRINT) Signature of Witness Date