Plymouth Pediatrics
71 Highland Street, Plymouth, NH 03264

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) BY PLYMOUTH PEDIATRICS

All sections of this form must be filled out completely or it will not be accepted.
I hereby authorize Plymouth Pediatrics to use/disclose my individually identifiable health information as described below (which may include information concerning treatment for drug/alcohol abuse, mental health, HIV status, or genetic testing records, if applicable). I understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that if the recipient authorized to receive the information is not a covered entity, such as insurance company or health care provider the disclosed information may no longer be protected by federal and state privacy regulations.

Patient Name: ______________________________________ DOB: _____________________

Address: ____ Phone Number: _____________

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Purpose of the use and/or disclosure:

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Description of information to be disclosed:

☐ Inpatient relevant dates: ____
Unless otherwise specified disclosure includes Discharge Summary, Operative Records, Laboratory Report/Test Results, Consultation Reports and Progress Notes.
Additional/specific information needed: ____

☐ Outpatient relevant dates or provider name: ____
Unless otherwise specified disclosure includes Ambulatory Care Notes, Laboratory Report/Test Resultsand Emergency Department Report.
Additional/specific information needed: ____

☐ Itemized Billing Records relevant dates: ____

The health information shall be disclosed to (check only one): □ Hospital □ Physician □ Insurance Company ☐ Attorney ☐ Patient ☐ Friend or Family Member ☐ Other

____

____

Name Address

____

____

City State Zip Code (OVER)

I understand that I may be charged for copies of my medical records.
I understand that this authorization will expire one year from the date of this authorization unless I otherwise specify.

(Alternative date if desired): ________________________________.
I further understand that I may revoke this authorization at any time by notifying Plymouth Pediatrics in writing at 71 Highland Street, Plymouth, NH 03264, except to the extent it has already been relied upon.

____ ___________________ ________________
Signature of Patient or Personal Representative Phone Number Date

____ _____________________________________
Printed Name of Personal Representative Legal Authority of Personal Representative

At your request we will provide you a copy of this form.

12/22/2010