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**AUTHORIZATION TO USE OR DISCLOSE CONFIDENTIAL MEDICAL INFORMATION**

1. **IDENTIFICATION OF PATIENT AND AUTHORIZATION:** I hereby authorize \_\_\_\_\_ (name of physician) to share my protected health information as set forth below for purposes in addition to those already permitted by law. Such information may be released at the request of the individual(s) to whom information may be disclosed, unless another purpose is stated below.

Patient Name				Date of Birth
Address		City	State	Zip
				Phone Number

2. **PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:**

Name	Address	Phone	Fax	E-mail	Purpose of use or disclosure:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

3. **INFORMATION TO BE DISCLOSED:**

\_\_\_\_\_ Entire Medical Record    \_\_\_\_\_ History/Physical    \_\_\_\_\_ Immunization Record  
 Other (list): \_\_\_\_\_

4. **COVERING THESE DATES OF SERVICE** (choose one): 1) between \_\_\_\_\_ and \_\_\_\_\_; 2) on (date) \_\_\_\_\_; 3) \_\_\_\_\_ All Dates.

5. **EXPIRATION AND REVOCATION.** This Authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_. I understand that I may revoke this authorization at any time by writing to the address listed above, but that such revocation will not apply to information that has been disclosed pursuant to this Authorization prior to the date upon which such revocation is received. If I do not specify an expiration date, this Authorization will expire 12 months from the date signed below.

6. **ACKNOWLEDGMENT OF UNDERSTANDINGS:** I understand and acknowledge the following:
- a. This Authorization is voluntary and will not affect my eligibility for treatment, payment of claims, enrollment, or eligibility for benefits from Norman Pediatric Associates.
  - b. Information disclosed pursuant to this Authorization is subject to being re-disclosed by the person who receives it, and may no longer be protected by privacy regulations.
  - c. I may inspect or obtain a copy of the protected health information shared under this Authorization by sending a written request to Norman Pediatric Associates at the address listed above.
  - d. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

Signature of Patient, Parent or Legal Guardian	Relationship to Patient (if applicable)	Date
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