Authorization for Use and/or Disclosure of Protected Health Information

Medical Record #:_____(completed by HTPC)

This form authorizes Hometown Pediatric Care to use and/or disclose protected health information in the manner described below and is voluntary. The information used or disclosed as a result of this authorization may be subjected to re-disclosure by the person or entity receiving such information and no longer protected by the federal privacy regulations

Please note that each section of the form must be completed in its entirety*. Failure to specify (including dates) will delay the processing of your request.*

PATIENT INFORMATION

Patient Name:_____ Gender: ☐ Male ☐ Female
Last First Middle

Date of Birth_____ Phone: (_____)_____-_____

Parent/Guardian/Requestor Completing Form:_____

RELEASE TO

Name: **JILL A. NEFF, DO** Organization (if applicable): **HOMETOWN PEDIATRIC CARE**

Address: **504 McCarty Lane, Ste 1** City: **Jackson** State: **OH** Zip Code:**45640**

Phone: **740-286-5455** Fax: **740-286-6782 OR 877-805-9492** **Email: info@hometownpediatric.com**

Information May Be: ☐Mailed ☐ Faxed ***IF MORE THAN 50 PAGES, MUST BE MAILED** ☐ Email:_____

PURPOSE

Records are to be released for the following purpose(s): *(Select all that apply)*

☐Transfer out of Practice ☐Attorney/Legal ☐ Personal ☐ Insurance ☐ Disability/SSI ☐ Continuity of Care

☐Other:_____

INFORMATION TO RELEASE

Dates of Treatment/Particular Illness/Admission Requested:_____

☐ **Copy of Complete Chart**

☐Summary of Current Problems & Medications ☐Copy of History & Physical

☐X-Ray Reports, Labs or Other Tests ☐Immunizations

☐Other:_____

PATIENT/PARENT/LEGAL GUARDIAN AUTHORIZATION

Unless otherwise revoked, this authorization will expire one (1) year from the date it is signed or, if specified, on the following date, event or condition (complete if desired):_____. This authorization may be revoked at any time. However, the revocation will not apply to uses or disclosures occurring prior to our receipt of your revocation request. In order to revoke the authorization, the individual/parent/legal guardian must submit a revocation request, in writing, to the Health Information Management department at the address below.

I, the undersigned, hereby authorize Hometown Pediatric Care (HTPC) to use and/or disclose information from my medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AID or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism and/or psychiatrics/psychological conditions to the above mentioned entity(s).

Signature of ☐Parent ☐ Legal Guardian (Check one):_____ Date:_____

Note: If Legal Guardian box is checked, documentation establishing guardianship must be provided or on record in order to comply with the above request

Signature of Patient:_____ Date:_____

(if 18 years of age or older OR is an emancipated minor)

WITNESS: _____ Date:_____

SUBMIT

Please verify that all sections are completed in full. Upon completion, please send form to :

Facility Name:_____

Address: _____City:_____State:_____ZIP:_____

Phone: _____ Fax:_____