

Primary Pediatric Medical Group, Inc.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ **Date of Birth** _____

I hereby authorize Primary Pediatric Medical Group ("PPMG") to use and disclose my /my child's individually identifiable Protected Health Information ("PHI") in the manner described below.

This authorization covers all PHI except:

- | | | |
|---|--|---|
| <input type="checkbox"/> Claims/Billing Information | <input type="checkbox"/> Mental Health Records | <input type="checkbox"/> Genetic Test Results |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> HIV Test Results | |

The amount of PHI that this authorization covers is:

- The entire PHI less the checked category(s) above.
- Limited to: _____

[Examples – "Laboratory results from July 1998"; "Mental health records from January 2003 to present"]

The recipient(s) of my /my child's PHI is (are): [Examples – school name, athletic program director, etc.]

I authorize my /my child's PHI to be used and disclosed:

- At the discretion of the physicians/nurse practitioners of PPMG.
- At my request (Examples - school, camp, or athletic forms).
- For _____ [SPECIFY PURPOSE]
- For CLINICAL TRIAL: I understand that PPMG may refuse provision of research-related treatment unless I sign an authorization for use and disclosure of my /my child's PHI for the research. I understand that I will not have access to my /my child's PHI while the clinical study is open, but will be provided access when the study is closed.

This authorization covers the duration of: _____ [SPECIFY DATE OR EVENT]

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying PPMG in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by PPMG in reliance on this authorization before PPMG receives my request for revocation or modification. I must sign my written request and send it to my /my child's primary office. Current addresses are:

Oakland Office
411 30th Street #212
Oakland, CA 94609

Castro Valley Office
20126 Stanton Avenue #200
Castro Valley, CA 94546

Alameda Office
1332 Park Street #200
Alameda, CA 94501

~Please reconfirm the address before sending any correspondence~

I understand that the person or entity (*school, attorney, camp, etc.*) that receives my /my child's PHI from PPMG may provide this information to others (with or without my permission), and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my /my child's PHI from PPMG. I voluntarily sign this authorization.

Signed: _____ **Date:** _____

If not signed by the patient, please indicate relationship:

- | | |
|---|--|
| <input type="checkbox"/> Parent, guardian or caregiver of a minor patient. | <input type="checkbox"/> Beneficiary or personal representative of a deceased patient. |
| <input type="checkbox"/> Guardian or conservator of an incompetent patient. | <input type="checkbox"/> Other _____ [SPECIFY RELATIONSHIP] |