Primary Pediatric Medical Group, Inc.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize:	**to disclose to:**
______________________	______________________
Name of Disclosing Party	Name of Recipient
______________________	______________________
Address	Address
______________________	______________________
City State Zip	City State Zip

Records and information pertaining to:

______________________	______________
Name of Patient	Date of Birth
______________________	______________
Address	Primary Doctor
______________________	______________
City State Zip	Telephone

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _________________(date).
REVOCATION: This authorization is also subject to written revocation by the patient/parent/guardian at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.
REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
SPECIFY RECORDS: Check the box, initial and/or sign to specify which type of information is to be disclosed.

MEDICAL INFORMATION	___________(Initial)
PSYCHIATRIC INFORMATION	________________________(Signature)__________(Date)
DRUG/ALCOHOL INFORMATION	________________________(Signature)__________(Date)
RESULTS OF AN HIV TEST	________________________(Signature)__________(Date)
GENETIC RECORDS	________________________(Signature)__________(Date)
OTHER HEALTH INFORMATION	_____________(Initial and specify below)

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The recipient may use the health information authorized on this form for the following purposes: ____

Please circle reason for request: Change in insurance coverage; Child moving to an "adult" doctor; Moving from the area; Dissatisfied with the Practice; Other_________

A copy of the authorization is as valid as the original.

Signature: ____________________________Relationship (if not patient): ___________________ Date: ________