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www.abcdpediatrics.com

Patient Authorization for Practice to Release
Protected Health Information to a Third Party

By Signing this authorization, I Authorize ABCD PEDIATRICS to use and/or disclose certain protected health information (PHI) about me to _____
(Name of Entity to receive the information)

This authorization permits ABCD Pediatrics to use or disclose the following individually identifiable health information about me (specifically describe the information to be disclosed, such as date(s) of service, type of service, types of service level of detail to be released, origin of information, ect.)

The Information will be used or disclosed for the following purpose:

If Requested by the patient, purpose may be listed as "at the request of the individual" the Purpose(s) is/are provided so that I can make an informed decision whether to allow the release of the information. This authorization will expire on the receipt of written notice from the patient, legal guardian, or other legal responsible party.

The Practice will receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this automation in order to receive treatment from ABCD Pediatrics. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA privacy rule. I have the right to revoke this authorization in writing except to the extent that the practice acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

ABCD Pediatrics
19238 Stonehue
San Antonio, TX 78258

Signed by: _____ Relationship to Patient: _____
(Signature of Patient or Legal Guardian)

Patients name: _____ Date: _____

Print Name of Patient or Legal Guardian_____

PATIENT/GARDIAN TO BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION