PREMIER PEDIATRICS, INC.

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Phone 303-655-1685

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Authorization for Use or Disclosure of Medical Records of:

Patient Name: _____ Date of Birth: _____ Sex: _____

Name of Parent/Legal guardian: _____

Street Address: _____City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Name of Practice to Disclose Records: _____

If different than above: Address: _____City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

You may use or disclose the following health care information (Circle all that apply)

- Only copies of immunization records, growth charts, last physical or well baby exam and any important data, excluding confidential information.
- All my health information maintained by the above practice.
  (If adolescent or emancipated minor, they must sign a release of confidential information below)
  Circle "include" or "exclude" for each of the following. If not circled, the information will not be included.)
  Include or Exclude: My health information related to drug abuse and/or alcohol abuse
  Include or Exclude: My health information related to HIV/AIDS
  Include or Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes.
- My health information relating to the following treatment or condition: _____
- My health information for the following date(s): _____
- Other: _____

You may disclose this information to:

Name or title of organization: _____

Address: _____City: _____ State: _____ Zip: _____

Reason for this authorization (Circle all that apply)

- At my request
- Other (specify): _____

My Rights

I understand I do not have to sign this authorization in order to get health care benefits from Premier Pediatrics for treatment, payment, or health care operations. However, a signature will be required if I am asked to take part in a research study, for marketing purposes or to receive health care when the purpose is to create health information for a third party.

I understand that I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above name practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are to fill out a revocation form available from the office, or by writing a letter to this office. I understand that once this office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name of patient or legally authorized individual Relationship (self, parent, legal guardian, etc.)

THIS AUTHORIZATION ENDS AFTER ONE YEAR FROM THE DATE ON THIS FORM, UNLESS REVOKED IN WRITING PRIOR TO ONE YEAR