

PHYSICIANS TO CHILDREN, INC.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable/protected health information (PHI) as described below. I understand that the information I am authorizing to be disclosed may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations.

Patient's name: _____ Date of Birth: _____

Persons/organizations providing information _____
Person/organizations receiving information _____

Specific description of information to be released/copied including date(s):

Purpose of the use/disclosure: please check

- Personal copy Over age 22 Insurance change Moving Doctor closer to home
- Going to Family Doctor Referral to specialist Other _____
- Dissatisfied with Physicians to Children (please state why) _____

The patient or the patient's representative must read and initial the following statements:

- a) I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials** _____
- b) I understand that I get a copy of this form after I sign it. **Initials** _____
- c) I understand that this authorization will expire on ___ / ___ / ___ or upon the event of _____. **Initials** _____
- d) I understand that I may revoke this authorization at any time by notifying the Privacy Officer at Physicians to Children in writing, but if I do, it will not have any effect on actions Physicians to Children took before it received the revocation. **Initials** _____
- e) I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the costs of supplies and labor and postage related to the production of my information. I understand that the charge for this service is **Initials** _____ the charge for this service is **\$.50** per page up to 50 pages; **\$.25** per page for 51 pages and up.

THE REQUESTED PHI WILL BE RELEASED WITHIN 15 DAYS OF THE RECEIPT OF THIS SIGNED FORM

Signature of patient or representative _____ Date _____

Printed name of patient's representative _____

Relationship to the patient _____ Daytime Phone: _____