Metro Pediatrics, P.C.

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AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ **Phone #** _____

I understand that my protected health information (PHI) may include information concerning sexually transmitted diseases, behavioral and mental services, HIV/Aids, and treatment for drug and alcohol abuse.
I authorize the use or disclosure/ transfer of the above-named individual's protected health information as described below:

__ Entire Medical Record
__ Immunization Only
__ Other _____

Purpose of Transfer: __ Change of Physician __ Change of Insurance __ Medical needs not met by facility.

__ Relocating/ Moving __ Convenience __ Aged Out

Is this a permanent transfer: Yes __ No__
I wish to: ___ Have records mailed ___ Pick up records __ Patient Portal

Information listed above will be transferred from: **Information listed above will be transferred to:**

Name: _____ **Name:** _____

Address: _____ **Address:** _____

- I understand that this Authorization is voluntary, and I have a right to refuse to sign. Metro Pediatrics, P.C. may not refuse to provide health care treatment to me if I do not sign.
- This authorization is effective for ninety (90) days unless revoked or terminated by the patient or patient's personal representative.
- I may revoke or terminate this authorization by submitting a written revocation to Metro Pediatrics, P.C. I should contact the officer manager to terminate this authorization.
- I understand that upon my request, I may see and copy the PHI described on this authorization.
- Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may then not be protected under the federal privacy regulations.
- I agree to release Metro Pediatrics P.C. its employees, and physicians from any and all liabilities and responsibilities for disclosure of the above information to the extent indicated and authorized pursuant to this signed authorization.

Signature of Patient – If over 16 years of age_____ **Date**_____

Signature of Parent/ Guardian_____

Relationship to patient_____