PEDIATRIC ASSOCIATES
645 North Arlington Avenue, Suite 620
Reno, NV 89503

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Purpose: This form is used to confirm the direction of an individual that we use or disclose protected health information for a particular purpose.

SECTION A: The Individual (or the Individual's Representative) confirming the authorization.
I authorize the use and/or disclosure of my protected health information as described in Section B below. I understand that this authorization is voluntary and made to confirm my direction.

Patient Name: _____ D.O.B.: _____
Please Print

Address: _____

City: _____ State: _____ Zip Code: _____

SECTION B: The use and/or disclosure being authorized.
Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed:

_____

_____

Entities Authorized to Use or Disclose: Name or specifically identify the persons and/or organizations that you are authorizing to make use of and/or disclose the protected health information described above:

_____

_____

Entities Authorized to Receive and Use: Name or specifically describe the persons and/or organizations to which you are authorizing us to disclose and/or let use the protected health information described above:

_____

_____

SECTION C: Purpose of Use or Disclosure of Protected Health Information.
This authorization for use or disclosure of protected health information is at the request of the individual. The following describes the purpose(s) of the requested use of disclosure of protected health information:

To continue medical care with Dr. _____

SECTION D: Expiration and Revocation:
Expiration: This authorization will expire on: _____

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.
Include this authorization in the patient's medical record.