Center of Excellence in Pediatric Neurology

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## Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45C.F.R. Parts 160 and 164)

Patient's Full Name ___________________________ Birth date _______________
Address ____________________________________ Social Sec. #_________________
______________________________________________ Phone # ________________________

**The above list patient authorizes the following healthcare facility to make record disclosure:**
Facility Name: _____________________________
Facility Address: ___________________________
City, St, Zip: ______________________________
Ph: ______________________________
Fx: _______________________________

**This information may be disclosed and used by the following individual/organization:**
Facility Name: _____________________________
Facility Address: ___________________________
City, St, Zip: ______________________________
Ph: ______________________________
Fx: _______________________________

**Please check Records to be released:**
__History and Physical __Laboratory Reports __Progress Reports
__Pathology Reports __Operative notes __Radiology Reports
__Other___________________ __All Records __Billing
Time period from ___________________to _________________

**Purpose of Disclosure**
__Referral to Specialist __Transfer of Care __Legal Investigation
__Insurance __Personal __Disability Forms
__Other: _____________________________

**SENSITIVE INFORMATION RELEASE:** I understand if my medical record or billing record contains information that references drug/ alcohol abuse, psychiatric care, mental health treatment, HIV/AIDS, I agree to its release.

I hereby authorize Center of Excellence in Pediatric Neurology to use or disclose protected health information regarding my child's care and treatment. I understand that information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law. If I am authorizing the disclosure of HIV- related information, the recipient is prohibited from re-disclosing the information without my authorization, unless permitted to do so under state or federal law.

- If the patient is 18 years of age or older, the patient must sign and date the form
- If the patient is 18 years of age or older and is incapable of signing, a substitute who is legally authorized may sign and date the form. You must indicate your legal authority after your signature.
- If the patient is 17 years of age or younger, a parent or legal guardian must sign and date the form, unless there is an exception under state or federal law.

**Print Name:** _________________________________ ☐ Self ☐ Other

**Signature:** _________________________________ ☐ Parent ☐ Guardian

**Date:** ______/_______/_______