AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Patient Name: ____ DOB: __________

Address: ____

____

Home Telephone: _______________________ Cell Phone: _____________________

Therapist Name: _________________________________ Phone Number: __________________________

I, ____________________________, give my permission for Children First Pediatrics including its employees and agents, as well as my therapist(s), to disclose to and receive from the following individual or organization information pertaining to my health (my "protected health information" or "PHI"), including information related to my current and previous psychotherapy or hospitalization, and any of my medical records given to Children First Pediatrics or my therapist(s) by another health care provider who has not prohibited re-disclosure of the record:

Name: ____

Address: ____

____

Phone Number: ______________________ Fax Number: ___________________

I permit the above-referenced disclosures for the following purposes:

[*Statement of specific purpose(s), e.g., "any purpose relating to my health, the payment for my health care, the study of mental health, research on the relationship between mental and physical health," etc.*]

I understand that once my PHI is shared based on this authorization, federal privacy law may not prevent the persons or entities receiving the information from further disclosing it to others. I also understand that I have the right to revoke this authorization at any time by sending a written notice of my revocation to Children First Pediatrics. Such revocation will prohibit reliance on this authorization after the date upon which Children First Pediatrics receives the notice, but I understand that the use and re-disclosure of PHI already disclosed prior to that date will not be subject to the revocation.

I understand that Children First Pediatrics may not condition my medical treatment or eligibility for medical benefits on my agreement to sign this authorization.

This authorization will remain in effect until ______________ or one year after the date of my signature below, whichever is sooner.

[Name of Patient]	Signature	Date
[Name of legal representative] *Authorized as [legal guardian or other] to act on behalf of [name of patient*]	Signature	Date

SIGNED COPY OF AUTHORIZATION TO BE PROVIDED TO PATIENT