Highland Pediatrics

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Authorization for Use or Disclosure of Protected Health Information

I, ____, hereby authorize Highland Pediatrics physicians to use and/or disclose my individually identifiable health information as described below:

I authorize **Highland Pediatrics, 4519 Hixson Pike, Hixson, TN 37343,** to **RECEIVE** health information on:

Patient Name(s): ____

Date of Birth(s): ____

Please RECEIVE the health information from the following person(s) or organization:

Name: ____

Address: ____

____

Phone#: ____________________ Fax # ____________________

Reason for REQUEST of health information:

☐ Change of Primary Care Physician
☐ Insurance Purposes
☐ Special Appointment
☐ Personal
☐ Other: ____

The following individually identifiable health information may be used and/or disclosed:
(Check All That Apply)

☐ Discharge Summary
☐ Face Sheets with Final Diagnosis
☐ Complications and Procedures
☐ History and Physical Records
☐ Notes
☐ Reports of Tests & X-rays
☐ Emergency Room Record
☐ Consultation Reports
☐ Immunization (Shot) Records
☐ Outpatient Clinic Notes
☐ Inpatient Records
☐ Outpatient Records
☐ Abstracts
☐ Physical Therapy
☐ Other: ____________________

Dates of treatment to be RELEASED: ____

I authorize the **release** of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions. (Please initial below.)

Substance Abuse________ Psychological/Psychiatric Conditions________ AIDS/HIV/OTHER STDs________

See Back

Prohibition on Conditioning of Authorization on: HP will not condition treatment on your signing these authorizations, unless:

> You are receiving research-related treatment: or the only reason the facility is providing you with health care is to make a report to a third party, such as your employer (i.e., fitness to return to work) or school (i.e., P.E. physical).

Redisclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Revocation: I understand that I may revoke this authorization at any time by Notifying Highland Pediatrics in writing by sending a letter to Highland Pediatrics at 4519 Hixson Pike, Hixson, TN 37343, or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Highland Pediatrics took before it received my revocation letter. For example, Highland Pediatrics cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding and controlling, and I understand that they take precedence over statements made in Highland Pediatrics' Notice of Privacy.

____ ____________________

Signature of Individual or Personal Representative *Date*

Printed Name of Individual's Representative, if Applicable: ______________________________

Rationale for Serving as Personal Representative to the Individual (i.e., Parent, Legal Guardian):

____

Expiration: This Authorization Will Expire ________________________ (No Longer than 90 Days)

FOR INTERNAL PURPOSES ONLY

When Highland Pediatrics is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received By: ______________________________ Date: ________________

Was a signed copy provided to the individual? ☐ Yes ☐ No