AIRWAY PEDIATRICS
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Authorization to Use or Disclose/Release/Obtain Protected Health Information

NOTE: IT CAN TAKE UP TO ONE WEEK TO PROCESS A RECORDS TRANSFER

Patient Name:_____ Date of Birth: _____

My Authorization
You may use, disclose or release the following health care information:

o ALL health care information in the patient's medical record

o Health care information in my medical records relating to the following treatment or condition:

_____

You may use or disclose health care information regarding testing, diagnosis and treatment for:

o HIV (AIDS virus) and sexually transmitted diseases

o Psychiatric disorders/mental health

o Drug and/or alcohol use

Preferred Method of delivery:

Mail: Address: _____City: _____ State: _____ Zip: _____
Fax: (833) 983-2962 Email(secure):_____Pick Up-Phone: _____

Airway Pediatrics may OBTAIN this health care information FROM:

Name, Facility, Organization, Physician (or name of parent if minor):

_____
Address: _____ City: _____ State: _____
Zip: _____Fax: _____Email: _____

Reason(s) for this authorization:

o Transfer of care

o Personal use

o Mutual exchange of information

This authorization ends:

o Never

o On (date): _____

o In 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment).

My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

• To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Airway Pediatrics based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

• Fill out a revocation form. A form is available from Airway Pediatrics, or

• Write a letter to Airway Pediatrics.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____

Signature of Patient, Parent or Legally Authorized Individual Date

_____

Printed Name if Signed on Behalf of the Patient Relationship (parent, legal guardian, personal representative)