Pediatrics, C & C Medical Associates
Authorization to Use, Disclose, or Obtain Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use, disclose, or obtain the following health care information (check all that apply):

☐ All health care information in my medical record

☐ Health care information in my medical record relating to the following treatment or condition:

_____

☐ Health care information in my medical record for the date(s): _____

☐ Other (e.g., X-rays, bills), specify date(s): _____

You may use, disclose, or obtain health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus) ☐ Sexually transmitted diseases

☐ Psychiatric disorders/mental health ☐ Drug and/or alcohol use

You may: **___ use or disclose this health care information to (Sent records to):**
___ obtain health care information from (Obtain records from):

Name (or title) and organization or class of persons:_____

Address (optional): _____ City: _____ State: _____ Zip: _____

Phone # ( ) _____ Fax# ( ) _____

Reason(s) for this authorization (check all that apply):

☐ at my request ☐ check only if [practice/ facility]requests the authorization for marketing purposes

☐ other (specify) _____ ☐ check only if [practice/facility] will be paid or get something of value for providing health information for marketing purposes

This authorization ends:

☐ on (date): _____ ☐ when the following event occurs: _____

☐ 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)

II. 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 take part in a research study or
- 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 [name of practice or health care facility] 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 the [practice/health care facility]. Or
- Write a letter to the [practice/health care facility].

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

_____

Patient or legally authorized individual signature Date Time

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)