KIDS CARE PEDIATRICS
108 Horner Lane, Latrobe, PA 15650
(p)724-537-2131 (f): 724-537-2153

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

PATIENT NAME:_____ **DOB:**_____

I authorize the use or disclosure of the above named individual's health information described below. The following individual(s) or organization(s) are authorized to make this disclosure:

_____

_____

_____

The information identified below may be disclosed to or used by:

Kids Care Pediatrics, 108 Horner Lane, Latrobe, PA 15650

I authorize the following information to be used or disclosed:

□ Problem List	□ Medication List	□ Allergy List
□ History/Diagnosis	□ Adm./Discharge Summary	□ Lab Results
□ X-ray/Imaging results	□ Consultation reports	□ Progress notes
□ Treatment Plan	□ Other_____	□ ENTIRE RECORD

This information for which I am requesting disclosure will be used for the following purpose:

□ My personal use □ Insurance (psychiatry)

□ To evaluate eligibility for life insurance/disability benefits

□ At the request of my attorney

□ Transfer of care to another physician □ Other_____

By signing this document, I understand that the information to be disclosed may include information relating to AIDS, HIV, voluntary inpatient or involuntary outpatient Mental Health Care, treatment for drug, alcohol, or substance abuse. I understand I have the following rights:

- Right not to sign – Refusal to sign will not affect your ability to obtain treatment by Kids Care Pediatrics except when health services are solely for the purpose of reporting to a third party. (Example: Pre-employment physical)
- Right to revoke – Your revocation will not apply to any release we have already made in response to this authorization. To revoke this authorization, you must submit a written revocation to Kids Care Pediatrics.
- Re-disclosure – I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulation.

I have read and understand this authorization and authorize the use and/or disclosure of health information as described above.

X_____ **Date:**_____
Signature of patient or legal guardian

Print Name: _____ Relationship to patient: _____

Form Expiration date:_____