

AUTHORIZATION

Pediatric Associates of Barrington, S.C.

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****

Purpose: This form is used to confirm the direction of an individual that we use or disclose protected health information for a particular purpose.

SECTION A: Psychotherapy Notes.

Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

*** SECTION B: The Individual (or the Individual's Personal Representative) confirming the authorization.**

I authorize the use and/or disclosure of my protected health information as described in Section C below. I understand that this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Parents
name
+
address

Name: _____

Address: _____

Telephone: _____

E-mail: _____

Patient Number: _____

Social Security Number: _____

*** SECTION C: The use and/or disclosure being authorized.**

Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed on this authorization):

Med
Info

Medical Records

Entities Authorized to Use or Disclose: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, who you are authorizing to make use of and/or to disclose the protected health information described above:

Entities Authorized to Receive and Use: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing us to disclose and/or let use the protected health information described above:

SECTION D: Purpose of Use or Disclosure of Protected Health Information.

Check one of the following to describe the purpose(s) of the use or disclosure:

This authorization for use or disclosure of protected health information is at the request of the individual. [Check only if the request is at the initiative of the individual who is the subject of the protected health information. If this box is checked, you do not need to check the following box.]

The following describes the purpose(s) of the requested use or disclosure of protected health information:

SECTION E: Expiration and Revocation.

Expiration: This authorization will expire (complete one):

- On ____ / ____ / ____
- On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Pediatric Associates of Barrington, S.C.
Telephone: 847-381-6700 Fax: 847-381-6828

Address: 27790 W. Highway 22, Suite 22, Barrington, IL 60010

P&P 1
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Inability to Condition Treatment. I understand that XYZ Physician Practice may not condition my treatment on my refusal to sign this authorization.

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

Name I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Sign Signature: X _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

**Include this authorization in the individual's medical record.
Send copy to the Privacy Officer.**