HOPE PEDIATRICS
3512 STATE ROUTE 257, SUITE 106
SENECA, PA 16346

PHONE: (814) 677-3717
FAX: (814) 677-8914

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Read entire document before signing

Patient Name: _____ DOB: _____

1. I authorize the use or disclosure of the above named individual's health information described below.

2. The following individual(s) or organization(s) are authorized to make this disclosure:
   Name: _____
   Address: _____
   _____
   Phone: _____ Fax: _____

3. The information identified below may be disclosed to or used by the following individual(s) or organization(s):
   Name: _____
   Address: _____
   _____
   Phone: _____ Fax: _____

4. The type of information to be used or disclosed (requested) is as follows:

☐ Immunization Records ☐ Consultation Report (please supply name of consulting physician)
☐ Operative Report: Procedure _____ Date _____
☐ Progress Note(s): Date _____ or Range of Dates _____
☐ Psychotherapy Notes ☐ **Entire Record**
☐ Other (Please give specific description) _____

SPECIAL AUTHORIZATION:
I understand that my medical records may contain alcohol/drug abuse, HIV/hepatitis status, and/or mental health information and I give **special authorization** to the health care provider/facility to release this information in my records to the person, physician, facility named above for the stated purpose. I further understand that I may revoke this authorization in writing and I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization.

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

☐ My personal use ☐ To evaluate my eligibility for life insurance coverage
☐ Insurance (psychiatry) ☐ To evaluate my eligibility for disability benefits
☐ **Transferring** ☐ At the request of my attorney: Name _____
Reason for transferring _____
☐ Other (please describe) _____

6. **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 regulations.

I have read and understand this authorization, and authorize the use and/or disclosure of the health information as described in this authorization. This authorization will remain in effect from the date signed above until _____.

_____ _____
Signature of patient (or personal representative) **Date**

_____ _____
Name of Personal Representative (if applicable) **Relationship to patient**