Westside Pediatric Clinic, P.C.

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AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

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Physicians

Catherine Lien, P.N.P.
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Claire McKinley, P.N.P.
Pediatric Nurse Practitioners

Connie DiStefano
Administrator

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

I authorize: ______________________ ______________________ ______________________
Name of Provider Address City, State Zip

to use and disclose a copy of the specific health and medical information described below regarding:

____ ______________________
Patient Name Date of Birth

to: ______________________ ______________________ ______________________
Name of Provider Address City, State Zip

For the purpose of: ____

____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist.

_______ Lab Reports
_______ Pathology Reports
_______ Diagnostic Imaging Reports X-Ray
_______ Entire Medical Record*
_______ Most Recent 5 Year History
_______ Clinician Office Chart Notes
_______ Billing Statements

**Recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.*

SEPARATE, SIGNED AUTHORIZATION FORMS ARE REQUIRED FOR THE FOLLOWING:

HIV/AIDS Related Records
Genetic Testing
Mental Health Information
Drug/Alcohol Diagnosis, Treatment or Referral Information

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

1. We cannot condition our provision of services or treatment to you on the receipt of this signed Authorization;
2. You may inspect a copy of the protected health information to be used or disclosed;
3. You may refuse to sign this Authorization; and
4. We must provide you with a copy of this signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

SIGNATURE: ______________________________ DATE: ______________
Patient

SIGNATURE: ______________________________ DATE: ______________
Patient Representative

Description of Representative's Authority: ______________________________