Barrington Pediatric Associates, Inc

Authorization to Disclose Confidential Health Care Information

Patient Name:_____ Date of Birth _____

Address: _____

_____ Phone number _____

I, _____, hereby authorize Barrington Pediatric Associates, Inc to release/disclose or receive my child's confidential health information to/from the following specified individual: (Send records to/or receive from)

Address: _____

_____

_____ Fax#_____

The information to be used or disclosed is:

__ history/physical __ x-ray report __ problem list

__ Immunization record __ office notes __ lab test

__ Other (specify) _____

The purpose(s) of the use or disclosure are: __ coordination of care __ at my request __ other(specify)_____

There is a $15 charge to release medical records, due at request.

Specific understanding: By signing this authorization form, you authorize the use or disclosure of you or your child's health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and as such information is no longer protected by federal health information privacy regulations.

You have the right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. You have a right to see and copy the information described on this authorization form in accordance with the policies of Barrington Pediatrics. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization you will have the right to revoke it at any time, except to the extent that Barrington Pediatrics has already taken action based upon your authorization. To revoke this authorization, please write to the Office Manager at Barrington Pediatrics. Unless otherwise revoked, this Authorization will expire on the following date or condition;_____. If I fail to specify an expiration date, event or condition, this Authorization will remain valid for not more the twenty four (24) months from the date this Authorization was signed.

By:_____ Date:_____

____ patient ____ parent ____ legal guardian