OUT

PEDIATRIC & ADOLESCENT MEDICAL ASSOCIATES, P.C.

117 W. Liberty Street
Rome, NY 13440
(315) 339-0401
Fax (315) 339-2957

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Child's Name:______________________________ DOB:______________________

Address: ____

I hereby authorize Pediatric & Adolescent Medical Associates, P.C. to

*1. Send my child's individually identifiable health information to:

____
(Doctor or Hospital)

____
(Address)

*2. Information to be sent / obtained:

___ Complete health record
___ Immunization record only
___ Other (specify information & dates): ______________________
___ Laboratory tests
___ X-ray reports

____

*3. Reason for disclosure: _____ Transferring Records _____ Consultation with above physician

Other: ____

*4. This authorization will remain in effect for (check one only)

_____ The period necessary to complete the above transaction _____ One year _____ 90 days

*Parent/Guardian Signature ____________________ Relationship______________ Date ____________

Patients age 18 & up Signature ____________________ Self ______________ Date ____________

5. Separate authorization is required for the release of information related to the items below. Initial each line if required.

___ AIDS or HIV care
___ Behavioral health services/psychiataric care
___ Alcohol or drug treatment
___ Pregnancy, contraceptives & sexually transmitted diseases
___ Other ____

Parent/Guardian Signature ____________________ Relationship______________ Date ____________

Patients age 18 & up Signature ____________________ Self ______________ Date ____________

For release of information in item 6 only.

6. I understand this authorization may be revoked in writing at any time, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to: Compliance Officer, Pediatric & Adolescent Medical Associates, 117 W. Liberty Street, Rome, NY 13440.
7. The recipient of the above information might disclose it to other people. PAMA has no way to prevent this re-disclosure and cannot be held liable for such re-disclosures.
8. By signing this authorization, I release & agree to indemnify & hold harmless PAMA, its successors and assigns, and its agents & employees, from and against any claim or cause of action based on the release of requested health records and/or health information I previously authorized.
9. I understand I do not have to sign this authorization. My failure or refusal to sign will not affect your child's treatment at PAMA.

*Must be answered to be a valid authorization to disclose information.