Authorization for Use/Disclosure of Protected Health Information (PHI) for Patient Over the Age of 18

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Print Patient Name: _____________________________________Patient Date of Birth: __________________

_________ I do NOT consent to give my PHI to anyone else at this time.

_________ I authorize the release of my **complete health record** (including records relating to Mental health, Communicable diseases (including HIV + AIDS) and treatment of Alcohol/Drug abuse).

_________ I authorize the release of my complete health record **with the exception of** the following:

_____ Mental health
_____ Communicable diseases (including HIV + AIDS)
_____ Alcohol/drug abuse treatment
Other (please specify): _________________________________

I authorize Center City Pediatrics to use and disclose the Protected Health Information (PHI) TO:

Print Name: ____

Relationship to Patient (Circle One): Parent Other: __________________

This authorization shall remain in effect for 1 year from the date it is signed.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signature of Patient: ____ Today’s Date: _____________________

REV: 1.22.20
Original Date: 11.25.19