

Request to SEND Protected Health Information to a Third Party

Patient's Name: _____ Date of Birth: _____

I request that Pediatric Associates of Davidson County, PC (PAoDC) send a copy of my protected health information (PHI), described below, to the following entity:

Business Entity Name: _____

Street Address: _____

City _____ State _____ Zip _____

Fax Number _____ Phone Number _____

Description of Protected Health Information to be disclosed (choose below):

____ Healthcare information relating to the following treatment, condition: _____

____ Healthcare information relating to the following dates of Service from ___ / ___ / ___ to ___ / ___ / 20___

____ All healthcare information

____ Other: _____

Restrictions: Only medical records originated through PADC will be provided. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my PHI may include data relating to sexually transmitted diseases, AIDS or HIV. It may also include information about mental health services and treatment of alcohol and drug abuse.

I understand I may revoke this authorization in writing at any time. I understand that a revocation does not apply to information already released. I also understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____.

If I fail to indicate an expiration date, event, or condition this authorization will expire one year from the date signed.

I understand that authorizing the disclosure of this health information is strictly voluntary. I can refuse to sign and I need not sign it to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure of my PHI and the information may not be protected by federal confidentiality rules.

I have read the above authorization for Release of Information and do acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____
Signature of Patient/Guardian or Authorized Representative

Printed Name of Authorized Representative

Date of Request: _____

Office Use Only

Type of ID Verified _____ Signature _____ Date _____

Date Released: _____ Fee Assessed: _____

Notes:
