In order to serve you, we need the following information. Please print.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Complete to permit the disclosure of information to Outside Entity OR Parent/Guardians if Patient is over 18 years of age)

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

1. AUTHORIZATION:

By signing this authorization, I authorize Margiotti & Kroll Pediatrics, P.C. to use and/or disclose certain protected health information (PHI) about me to:

Name of Person/Entity **Receiving** Information:	Relationship to Patient: (if applicable)

2. EFFECTIVE PERIOD :

This authorization for release of information covers the period of healthcare from:

A:	☐	Start Date:	End Date:

****OR****

B:	☐	All past, present, and future periods.

3. EXTENT OF AUTHORIZATION :

A:	☐	I authorize the release of my complete health record (including but not limited to records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

B:	☐	I authorize the release of my complete health record with the exception of the following information:
		☐ Mental health records; ☐ Communicable diseases (including HIV and AIDS); ☐ Alcohol/drug abuse treatment; ☐ Other (Please specify): _____

4. 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;
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires;
6. I understand 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 at the insurer has a legal right to contest a claim;
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization;
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/Guardian/Personal Representative/ Signature:	Date:
Printed Name of Patient/Guardian/Personal Representative:	Relationship to Patient:
	Patient Phone Number: