Purohit Pediatric Clinic, LLC

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient's Name _____ Date of Birth _____

Street Address _____ City, State, Zip _____ Phone # _____

Obtain Records From:

Name of Healthcare Provider _____

Street Address _____

City, State, Zip _____ Phone # _____

Release Records To:

Name of Healthcare Provider _____

Street Address _____

City, State, Zip _____ Phone # _____

Information To be Released:

___ Entire Record (PLEASE MAIL RECORDS OVER 20 PAGES)
___ Consultations
___ Laboratory Reports
___ Other (specify)_____
___ Surgical Reports
___ X-Ray Reports
___ Consultations
___ Immunizations
___ Allergy Records

Purpose for Need of Disclosure:

___ Further Medical Care
___ Insurance Purposes
___ Other (specify)_____
___ Legal Action
___ Changing Physicians
___ Personal

I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans or health care clearing houses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights With Respect To This Authorization:

Right to Inspect or copy the Health Information to be used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacts Purohit Pediatric Clinic. Right to Receive a Copy of This Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form. Right To Refuse to Sign This Authorization – I understand that I am not under obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Rights to Withdraw This Authorization – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Purohit Pediatric Clinic, LLC. I am aware that my withdrawal will not be affective as to uses and/or disclosures of my health information that the person(s) and/ or organization(s) listed above have already made in reference to this authorizations.

Expiration Date: This Authorization is good until the following date_____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am not confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative:_____ **Date:**_____
(if not patient signature please state relationship to patient)

Witness:_____