AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

www.brightfuturepediatrics.com · 120 Old Camden Road, Camden, DE 19934 · Phone: 302.883.3266 · Fax: 302.883.3084

Patient(s) Name: ______________________ **Date of Birth:** ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

I hereby authorize the use and disclosure of my child's Protected Health Information (medical record) as described in the HIPAA Notice of Privacy Practices dated 9/23/13 and understand and acknowledge the following:

- I understand that I have the right to refuse to sign this authorization.
- Bright Future Pediatrics, LLC will not condition my child's (children's) treatment or payment for my child's (children's) treatment on obtaining this authorization from me, unless permitted by law.
- I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
- I understand I have the right to request a restriction as to how my child's/children's Protected Health Information is used or disclosed to carry out treatment, payment or health care operations of the Bright Future Pediatrics, LLC. Bright Future Pediatrics, LLC is not required to agree to the restrictions that I may request. However, if Bright Future Pediatrics, LLC agrees to a restriction that I request, the restriction is binding on Bright Future Pediatrics, LLC.
- I have the right to revoke this authorization at any time in writing and submit my written revocation to the Privacy Officer at Bright Future Pediatrics, LLC. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective as of the date the Privacy Officer receives the revocation.

I acknowledge that I have received a copy of Bright Future Pediatrics, LLC Notice of Privacy Practices dated 9/23/13 and I understand that I may request a copy of the most current Notice of Privacy Practices at any time.

I authorize Bright Future Pediatrics, LLC to send vaccination records and/or health appraisal forms via facsimile or email to daycare facilities, schools, camps or other health care facilities upon verbal request by myself or other named parent/guardian. I understand that Bright Future Pediatrics, LLC may verify the requestor's identity by requesting patient's demographic information such as patient's address, phone numbers and appointment information.

I understand that I must complete the Bright Future Pediatrics Medical Records Release form to request the specific release of my child's personal health records to a specific person or organization. Additionally, I must select the specific personal health information to be released and state the specific purpose for such authorized use or disclosure of the my child's protected health information.

I permit a copy of this authorization to be used in place of the original.

______________________________ ______________________________

Signature of Patient or Legal Representative **Date**

Relationship to Patient *(if applicable)*

Parent or Guardian of Unemancipated Minor

Court Appointed Guardian

Executor or Administrator of Decedent's Estate

Power of Attorney

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Printed Name of Patient's Representative *(if applicable)*

FOR OFFICE USE ONLY

The patient presented to the office on ___________________ was provided with a copy of the Bright Future Pediatrics LLC Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of receipt of the Notice. However, such acknowledgement was not obtained because:

Patient or Legal Representative refused to sign.

The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.

Patient or Legal Representative was unable to sign or initial because:

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Other reason (describe below):

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______________________________________ ______________________________

Signature of Employee Completing This Section Date