PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION*

I understand _____ is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize Kids' Doc or his/her designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

1. Description of the information to be used or disclosed (check as appropriate):

☐ **a. My entire record:**
I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic information, patient histories, medication lists, tests, and diagnoses. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to **(check all that apply)**:

- ☐ Alcohol and Drug Abuse Treatment*
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment
- ☐ Genetic Information (including, but not limited to, Genetic Test Results).

(NOTE: If you checked "my entire record," please skip to number 2. Otherwise, please continue with b. and c. below.)

☐ **b. My demographic information (check "All" or those that apply):**

☐ All ☐ Age ☐ Gender ☐ Race ☐ Other_____
☐ Name ☐ Address ☐ State/Zip Code Only ☐ Telephone

☐ **c. Medical Data/Information as related to (check all that apply):**

- ☐ Specific condition(s):_____
- ☐ Specific professional service(s):_____
- ☐ Specific medication(s):_____
- ☐ Alcohol and Drug Abuse Treatment:*
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment:_____
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS):_____
- ☐ Genetic Information including, but not limited to, Genetic Test Results:
- ☐ Other: _____

2. Please disclose the above information to:

Name/Entity:_____ Telephone:_____
Address:_____
Telephone:_____ Fax:_____

3. **I ☐ do ☐ do not authorize this information to be disclosed electronically.**

4. **Purpose(s) for disclosure of the information:**

_____

_____

(NOTE: If the patient is requesting disclosure, the purpose may simply state: "Patient is requesting disclosure.")

5. **Right to revocation**. I have a right to revoke this authorization in writing (or orally in the case of Part 2 alcohol and drug abuse services), except to the extent that action has been taken in reliance on this authorization. Kids' Doc must receive the revocation in writing (except for Part 2 alcohol and drug abuse services) and the written revocation must include:

   a. My name and address,
   b. The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
   c. My desire to revoke this authorization, and
   d. The date of the revocation, and my signature.

   Kids' Doc will accept written revocations of this authorization via:

   ☐ Certified U.S. mail ☐ Facsimile at this number: **(817) 795-9700**

   ALL written revocations must be sent to **Kids' Doc**, and are not effective until received by him/her.

6. **This authorization shall expire on _____.** After this date/event, Kids' Doc can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form. ***If no expiration is designated this authorization will expire six (6) months from the signature date.***

7. I fully understand and accept the terms of this authorization.

_____ _____

Name of Patient **Date of Birth**

_____ _____

Name of Parent/Legal Guardian **Relationship to Patient**

_____ _____

Signature of Parent/Legal Guardian **Date**

***CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS**

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 C.F.R. Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general Authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR OFFICE USE ONLY

☐ Authorization added to the patient's record on _____.
☐ Authorization verified by _____ on _____.
☐ Patient has been provided with a copy of the signed authorization.

Medical Records Information

1. **Authorization of Minors:** for patients under 18 years of age the authorization must be signed by a parent or legal guardian. The records must be picked up by the parent or legal guardian who signed the authorization. KIDS' DOC reserves the right to request proof of representation.

2. **Medical Records Fees:** $25.00 for the first 20 pages and $0.50 per page thereafter and additional costs for mailing, shipping or delivery. Payment is required the day the records are requested.

3. **Immunization Record fee:** $15.00 and additional costs for mailing, shipping or delivery. Payment is required the day the records are requested.

4. **FMLA, Letters and Misc. Form Fees:** $15.00 to $50.00 and additional costs for mailing, shipping or delivery. Payment is required the day the records are requested.

5. **Completion of records:** Kids Doc will furnish the records within 15 business days after the date of receipt of the request.

6. **Facsimile:** kids' Doc will **not** send medical information by facsimile.

7. Mailing Address: Kids' Doc Pediatrics
   2624 Matlock Road
   Arlington, TX 76015