

**PEDIATRIC
SURGICAL ASSOCIATES**

GENERAL, THORACIC & MINIMALLY INVASIVE SURGERY

every child deserves our best

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**AUTHORIZATION FOR USE AND DISCLOSURE
OF PERSONAL HEALTH INFORMATION**

This authorization is prepared pursuant to the requirements of the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164) ("HIPAA Privacy Rules"). This authorization affects your rights in the privacy of your personal health information. Please read carefully before signing.

(Please Print)

Patient's Name: _____ **Patient's DOB:** _____

Patient Account Number: _____

I request and authorize Pediatric Surgical Associates, P.A. to release personal health information on the patient named above to the following representative:

Name: _____ **Contact Phone:** _____

Address: _____ **Fax:** _____

This request and authorization applies to all information concerning the case history, treatment and examinations, including copies of hospital and medical records, of the patient named above relating to the approximate period of time from _____ to the present.

I understand that I may revoke this request and authorization, in writing, at any time. Any exceptions to this right to revoke, and a description of how this request and authorization may be revoked, are included in the HIPAA Privacy Notice prepared by Pediatric Surgical Associates and provided to me.

I understand that my refusal to sign this authorization will not adversely impact the treatment, payment, enrollment or eligibility for benefits in a health plan of the patient named above.

I understand that once Pediatric Surgical Associates, P.A. discloses information pursuant to this request and authorization, Pediatric Surgical Associates has no further control over the use or disclosure of that information.

Signature of Patient or Patient's authorized representative

Date

Relationship or status if signed by Patient's authorized representative (i.e. Parent, Legal Guardian, etc.)

Signature of Witness

Address

Phone