Patient Authorization to Use or Disclose Protected Health Information

I, _____ , understand **Londonderry Pediatrics, PA** is authorized by me to use or disclosure my protected health information for a purpose 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 specifically authorize any current employee or owner of **Londonderry Pediatrics, PA** or any other individual listed below 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 health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be used or disclosed (check all that apply): Patient Name _____ DOB _____

❑ The patient's entire medical record (NOTE: This requires an explanation why the entire record may be disclosed).

❑ The patient's demographic information (check all that apply): ❑ Name ❑ Address ❑ State/Zip Code only ❑ Telephone ❑ Age ❑ Gender ❑ Race ❑ Other: _____

❑ Medical Data/Information as related to:

❑ Specific condition(s): _____ ❑ Specific professional service(s): _____

❑ Specific medication(s): _____ ❑ Immunization Record _____

❑ Other: _____

_____

Name(s) of person(s) other than current employees or owner(s) authorized by this form to use and disclose the patient's protected health information: _____

_____

Name(s) of person(s) authorized by this form who may use and disclose the patient's protected health information: _____

_____

_____

Purpose(s) of the information: _____

_____

❑ *(Check if applicable)* This authorization is to be used for our own use, and **Londonderry Pediatrics, PA** will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

❑ *(Check if applicable)* The patient understands that **Londonderry Pediatrics, PA** may receive financial gain as a result of disclosing this information due to

_____

❑ *(Check if applicable)* This authorization permits **Londonderry Pediatrics, PA** to send the protected health information ONLY to this address or fax number:

_____

Any other address or fax number is not permitted by this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, **Londonderry Pediatrics, PA** must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Londonderry Pediatrics, PA will accept written revocations of this authorization via:

❑ Certified U.S. mail ❑ Facsimile at this number: (603) 421-0868

All revocations must be sent to **Londonderry Pediatrics, PA** to the attention of the **Privacy Officer,** Jeannine T. Bailey and not effective until received by the Privacy Officer.

This authorization shall expire on _____ . After this date, **Londonderry Pediatrics, PA** can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Patient's Signature _____ Date _____

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on _____.

Authorization verified by _____ on _____ .