HELPING HANDS PEDIATRICS INC.

585 EAST STATE ST.
SHARON, PA. 16146

26 NESBITT RD., SUITE 400
NEW CASTLE, PA 16105

724-346-6494
724-346-3018 FAX

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION OUTGOING

PATIENT NAME:_____
ADDRESS:_____
PHONE:_____
DATE OF BIRTH:_____

I AUTHORIZETHE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S HEALTH INFORMATION AS DESCRIBED BELOW:

___X___ IMMUNIZATION RECORDS
___X___PHYSICAL EXAMS
___X____ LABS/XRAYS
___X____ CONSULTATIONS

COMPLETE MEDICAL RECORDS FOR THE ABOVE NAMED CHILD

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE:

HELPING HANDS PEDIATRICS INC.

THE INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING ORGANIZATION:
NAME:_____
ADDRESS:_____
PHONE:_____ **FAX:**_____

I UNDERSTAND THAT IF THE ORGANIZATION AUTHORIZED TO RECEIVE INFORMATION IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER; THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE SIGN DATE. I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS HEALTH INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THIS AUTHORIZATION. I NEED NOT SIGN THIS FORM IN ORDER TO RECEIVE TREATMENT. I UNDERSTAND THAT I MAY INSPECT OR COPY THE INFORMATION TO BE DISCLOSED. I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED REDISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES.IF I HAVE QUESTIONS ABOUT THE DISCLOSURE OF MY HEALTH INFORMATION, I CAN CONTACT: ANGIE CHLPKA, SECURITY OFFICER AT 724-346-6494.

_____ _____

SIGNATURE OF PARENT OR GAURDIAN AND DATE

SIGNATURE OF WITNESS AND DATE

DATE FAXED:_____

INITIALS OF FAXER:_____