All portions of this form must be completed to contitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be concidered defective.

Patient's Name	Date of Birth	SSN
Address	Phone #	Medical Record #

I authorize the use and disclosure of health information about the above named pation as described below**

Name, Adress, and phone number of Faclity Authorized to **Release** Health Information:
Name, Adress, and phone number of Faclity Authorized to **Receive** Health Information:

Health Information that may be used / disclosed is limited to the following:

Discharge Summary	Consultation(s)	Pathology report	Lab
History & Physical	Operative Notes(s)	Imaging/X-ray	Entire Record
Other (specify)			

*** **There is a charge for copying Medical Records**

Health Information to be released to the above named agency / individual is to be used / disclosed for the following Treatment **Dates**:
Health information to be released to te above names agency / individual is to be used / disclosed for the following purposes(s): Health information identifies you (the patient) by name, and includes demographics information about you. Health information may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.
I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.
Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the pecipient and no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.
This authorization will automatically expire 60 days after the date below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have the right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.
Treatment, payment, enrollment or eligibility for benefits may not be conditional on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.		
Patient's or Authorized Personal Representative's Signature	Date	Time
Relationship to patient / Authority to Act on Patient's Behalf	Interperter, if utilized	
Witness Signature	Experation Date or Event	

*** There is a charge for copying Medical Records.

Authorized to Use and Disclose Protected Health Infromation

MONCLOVA ROAD PEDIATRICS