AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I HEREBY AUTHORIZE **VAN METER PEDIATRIC ENDOCRINOLOGY, P.C.** TO USE OR DISCLOSE THE FOLLOWING HEALTH INFORMATION:

- ☐ COMPLETE MEDICAL RECORD
- ☐ HEALTH INFORMATION DATING FROM _____ TO _____
- ☐ OTHER

_____

VAN METER PEDIATRIC ENDOCRINOLOGY, P.C. MAY DISCLOSE THIS HEALTH INFORMATION TO:

_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NUMBER _____ FAX NUMBER _____

THE PURPOSE OF THIS AUTHORIZATION IS (CHECK ALL THAT APPLY):

- ☐ TRANSITION OF CARE
- ☐ CONTINUING CARE
- ☐ OTHER

_____

THIS AUTHORIZATION IS VALID:

- ☐ INDEFINITELY
- ☐ DATING FROM _____ TO _____

BY SIGNING THIS AUTHORIZATION, I UNDERSTAND THAT:

- I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. SUCH REVOCATION MUST BE MADE IN WRITING AND WILL NOT APPLY TO OR EFFECT INFORMATION THAT HAS ALREADY BEEN USED OR DISCLOSED BASED ON MY ORIGINAL PERMISSION.
- I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION. A COPY OF THIS AUTHORIZATION IS VALID AS THE ORIGINAL.
- I AM SIGNING THIS AUTHORIZATION VOLUNTARILY. TREATMENT, PAYMENT, OR ELIGIBILITY FOR BENEFITS WILL NOT BE AFFECTED IF I DO NOT SIGN THIS AUTHORIZATION.
- ANY PERSON / ENTITY / PRACTICE TO WHOM HEALTH INFORMATION IS DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY NOT FURTHER USE OR DISCLOSE THIS INFORMATION UNLESS ANOTHER AUTHORIZATION IS OBTAINED FROM ME (OR UNLESS SUCH DISCLOSURE IS SPECIFICALLY REQUIRED OR PERMITTED BY LAW).

SIGNATURE OF PATIENT: **DATE:**

OR

PRINT NAME OF RESONSIBLE PARTY:

SIGNATURE OF RESPONSIBLE PARTY: **DATE:**