Meridian Pediatrics

Competence
Caring
Compassion

Office Use Only: ☐ Faxed ☐ Mailed ☐ In person/ID checked

AUTHORIZATION TO USE DISCLOSE PROTECTED HEALTH INFORMATION

Patient: _____ Date of Birth: _____

Address: _____

_____

Phone: _____

Release Information From:	**Release Information To:**
☐ Meridian Pediatrics	☐ Meridian Pediatrics
☐ Other: (Specify Name, Address, Phone)	☐ Other: (Specify Name, Address, Phone)
_____	_____
_____	_____
_____	_____

1. **Relevant Time Period.** The entity/person listed above may use or disclose information relating to healthcare provided during the following time period:
   - ☐ Anytime.
   - ☐ Healthcare provided between (*date*) _____ and (*date*) _____.

2. **Types of Information.** Meridian Pediatrics may use or disclose the following type(s) of information:
   - ☐ Any information concerning the Patient's healthcare or payment during the relevant time period.
   - ☐ Medical records concerning the Patient's healthcare during the relevant time period, including:
     - ☐ Records from the Patient's chart (*e.g.*, history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, *etc.*)
     - ☐ Diagnostic images, films or other recordings (*e.g.*, x-rays, MRI scans, CT scans, *etc.*)
     - ☐ Psychotherapy notes ***[Note: These cannot be combined with authorization for other records]***
   - ☐ Billing and payment records for healthcare rendered during the relevant time period.
   - ☐ Other: _____

3. **Purpose.** Meridian Pediatrics may use or disclose the information for the following purpose(s):
   - ☐ The disclosure is made at the Patient's request.
   - ☐ For a potential or pending legal proceeding.
   - ☐ For marketing. Meridian Pediatrics *will/will not (circle one)* receive remuneration form a third party for the use or disclosure of the information.
   - ☐ Other: _____

I understand that I have the right to revoke this authorization at anytime except to the extent that Meridian Pediatrics has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:

Meridian Pediatrics Medical Records Department

I understand that Meridian Pediatrics may not condition the Patient's healthcare on this authorization unless (1) the purpose for Meridian Pediatric's evaluation and treatment is to obtain and disclose information to entities consistent with this authorization, or (2) the Patient is involved in research-related treatment and the use or disclosure is for such research.

I understand that information disclosed by Meridian Pediatrics pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

This authorization will expire on the following date or event: _____.
If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

_____ _____

Signature Date

_____

Authority or relationship to the Patient

** Give a copy of the authorization to the Patient or personal representative.*