Albemarle Pediatrics

Authorization for Use or Disclosure of Information

Phone# 704-982-5437 Fax # 704-982-4843

I hereby authorize _____to:

_____ Use the following protected health information and/or

_____ Disclose the following protected health information to _____

Information Authorized for use and/or disclosure (check all that apply):

- ☐ Medical Records from the last 4 years
- ☐ Immunizations ONLY
- ☐ Other _____
- ☐ Newborn Records ONLY
- ☐ Entire Medical Records, including all Psychotherapy Notes

This protected health information will be used or disclosed for the following purpose:

- ☐ Transfer of Patient Care
- ☐ Patient Care
- ☐ At the request of the individual

Format (only select one):

- ☐ Paper copy
- ☐ Electronic copy
- ☐ CD
- ☐ Other _____

Delivery Method:

- ☐ Reg.US Mail ☐ Fax
- ☐ Pickup (If not picked up in 90 days will be shredded/2nd request will be a $35 fee)
- ☐ Other _____

This authorization will expire in 1 year.

I understand that I have the right to revoke this authorization at any time by sending written notification to:

Albemarle Pediatrics
Attn: Privacy Officer
1420 US HWY 52N, Suite A
Albemarle, NC 28001

- I understand that the PHI may include information relating to mental health/drug, alcohol treatment and/or HIV, AIDS, or communicable disease and psychotherapy notes.
- I understand that if I revoke this authorization, the revocation is not effective to the extent that Albemarle Pediatrics has relied on the use or disclosure of the information.
- Albemarle Pediatrics may not condition my treatment or payment on whether I sign an authorization for the requested use or disclosure.
- I understand that the information used or disclosed, based on this authorization, may be subject to re-disclosures by the recipient and no longer protected by Privacy Rules.
- Albemarle Pediatrics, its employees, officers, agents, and physicians and independent health care personnel who treat patients at Albemarle Pediatrics are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that I also have the following rights:
  - Right to inspect or copy the information to be used or disclosed
  - Right to refuse to sign this authorization

_____ _____

Signature of Patient/Personal Representative Print Name of Signature

_____ _____

Print Name of Patient and Date of Birth Today's Date

NOTE: A copy of the completed, signed authorization will be provided to you by Albemarle Pediatrics