ALL CHILDREN PEDIATRICS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NOTICE:

- Federal law says that our practice cannot share your child's Health Information without your permission except in certain situations. If you sign this form, your are giving All Children Pediatrics, PLLC permission to share your child's Health Information that All Children Pediatrics, PLLC has with the person or entity you indicate below.
- This Authorization is voluntary.
- **Right to Revoke:** If you decide that you do not want All Children Pediatrics, PLLC to share your child's Health Information any longer, sign the Revocation at the end of this form and give this form to All Children Pediatrics, PLLC.
- Payment, enrollment or eligibility for benefits for your child's health care will not be affected if you do not sign the Authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- All Children Pediatrics, PLLC cannot promise that the person you permit All Children Pediatrics, PLLC to share your child's Health Information with will not share your child's Health Information with someone else you may not want to have your child's Health Information.
- You can keep a copy of the Authorization, and can contact All Children Pediatrics, PLLC to obtain a copy if you do not have one.

AUTHORIZATION SECTION

I, _____(Parent/Guardian) hereby authorize the use and disclosure of the following health information that pertains to my child:

Patient Name:_____ Date of Birth:____/____/____

(check all that apply)

- □ All of my child's Health Information
- □ Information regarding prescription drug coverage
- □ My child's Health Information regarding acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus
- □ My child's Health Information regarding treatment for alcohol and/or substance abuse
- □ My child's Health Information regarding behavioral health services or psychiatric care
- □ Other:_____

I understand that All Children Pediatrics, PLLC may share my child's Health Information for one year from the last date of service/seen by this practice or until I revoke the Authorization. I further understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

This form must be signed by EITHER the Parent/Guardian OR by the Personal Representative. The patient's Parent/Guardian may sign for the patient if the patient is a minor.

_____ _____ _____

Signature of Patient/Parent/Guardian/ Relationship Date

If this form is signed by the Personal Representative, please include a copy of the document naming the Personal Representative, for example, a Power of Attorney, Personal Representative Designation form, or other appointed guardian or executor.

_____ _____ _____

Signature of Personal Representative Relationship Date

REVOCATION OF AUTHORIZATION

I no longer want All Children Pediatrics, PLLC to share my health information with the person or entity indicated above.

My name (print)_____ Relationship_____ Date_____

Signature_____

Send this Authorization Form or Revocation of this Authorization to:

Privacy Officer
All Children Pediatrics, PLLC
400 Blankenbaker Parkway, Suite 200
Louisville, KY 40243 FAX: 502-244-9860

Contact information for All Children Pediatrics, PLLC
Privacy Officer:
400 Blankenbaker Parkway
Suite 200
Louisville, KY 40243
Phone: 502-244-6373