Lake Lewisville Pediatrics, L.L.P.
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-HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I. ***THE PATIENT.*** This form is for the use when authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

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

Address: _____ Phone Number: _____

II. ***AUTHORIZATION*****.** I authorize Lake Lewisville Pediatrics, LLP (Authorized party) to use or disclose the following information: **(check one)**

___ All medical-related information.
___ Medical information ONLY related to _____.
___ Medical Related information from ___/____/____ to ____/____/_____
___ Other: _____

III. **DISCLOSURE.** The Authorized Party has my authorization to disclose Medical Records to:
If a Minor, please include information of any parent/guardian, other than yourself, that is legally authorized to access the patient's medical related information.
Name: _____ Name: _____
DOB: ____/_____/_____ DOB: _____/_____/_____

IV. **PURPOSE.** The reason for this authorization is: (please initial)
_____ General Purpose. Release and sharing of records at my request.
_____To Receive Payment. To allow the Authorized Party to communicate with me for insurance purposes when they receive payment from a third party.
_____ Other: _____.
a. **SENSITIVE INFORMATION**. (please check) This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate Consent must be given before this information can be released. _____ I Consent to have the above information released.
_____ I DO NOT Consent to have the above information released.
b. **HIV/AIDS.** This medical record may contain information concerning HIV testing and/or AIDS diagnosis and treatment. Separate consent must be given to have this information released. (Check One) _____ I Consent to have the above information released.
_____ I Do NOT Consent to have the above information released.

V. **TERMINATION.** This authorization will terminate on:_____ Upon Sending written revocation to the Authorized Party.

_____ On the following Date: _____/_____/_____

VI. ACKNOWLEDGEMENT OF RIGHTS.

· I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance or other party has legal rights to PHI (protected health information).

· I understand that uses and disclosures already made based upon my original permission can not be taken back.

· I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

· I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create the medical records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

· I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original authorization.

Signature of Patient (18 and older): _____ Date: ___/___/_____

Print Name: _____

The patient is unable to sign due to: (check one if applicable)

____ Being a Minor. Patient is ____ Years/months old and is considered a minor under state law.

____ Being Incapacitated. Patient is incapacitated due to: _____.

____ Other: _____.

Signature of Representative/Parent/Guardian (if under 18): _____ Date: __/__/__

Print Name: _____ Relationship to Patient: _____