

Northpoint Pediatrics

Patients 18yr and older -Authorization for Release of Protected Health Information

1. Patient Information:

Patient's Name: _____ Patient's Date of Birth: _____

Patient's Address: _____ Patient's Cell Number: _____

Name of Primary Care Doctor: _____

I hereby authorize and consent to disclosure of health records as stated below. I am aware that the records disclosed might contain records whose confidentiality is protected by either the Federal Drug & Alcohol Confidentiality Law (42 C.F.R. Part 2) or the State Mental Health Records Law (I.C. 16-39-2). I understand the records released may include alcohol and/or substance abuse, mental health and communicable disease documentation (including HIV results) unless I specifically prohibit the release of this information.

2.

_____ a. I authorize Northpoint Pediatrics to release records to my parents / guardians.

Please list parent / guardian names here: _____

List what items you DO NOT want to be released here:

_____ b. I do not authorize Northpoint Pediatrics to release records to my parents / guardians.

3. This request may be revoked by the patient at any time by communicating in writing that intent to the provider.

4. I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. However will make me responsible for my account at Northpoint Pediatrics.

PATIENTS 18 YEARS AND OLDER, ARE HIS/HER OWN LEGAL GUARDIAN AND MUST SIGN THIS FORM TO RELEASE MEDICAL RECORDS INFORMATION.

Patient Signature

Printed Name

Date Signed

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Office use only:

Release scanned into medical chart: _____ Date Completed: _____

JMJ chart alert added: _____ Date Completed: _____

BSDC credit msg added: _____ Date Completed: _____

Update X box: _____ Date Completed: _____