



Previous Physician:

Name: _____

Location: _____

Phone: _____

Fax: _____

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize _____ to use and/or disclose certain protected health information (PHI) about me to:

Person or Entity to Receive the Information:

Latham Pediatrics **Phone:** 518-783-3110 x5
711 Troy Schenectady Rd. Suite 101 **Fax:** 518-783-7506
Latham, NY 12110.

This authorization permits the entity above to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

 Transfer of care _____

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on: _____
{Expiration Date or Defined Event}

Unless specified otherwise above, this authorization shall expire one year from the date below.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

Signature of Patient or Legal Guardian

Print Name of Patient

Relationship to Patient: _____

Patient Date of Birth: _____

Date: _____