Authorization for Disclosure of Protected Health Information

Pediatric Form

Patient Name:	**Patient Date of Birth:**
Patient Address:	

Applies to family members or other individuals specified by the patient.

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Christian Health Service of Syracuse may not use or disclose information, except as provided in our Notice of Privacy Practices, without your authorization.

☐I do not wish to release my health information to anyone at this time.

☐Release my health information to the following members of my family or individuals specified by me. Authorization is granted to the listed individuals:

~Name: ________________________________Relationship to Patient: __________ Phone #: _______________

~Name: ________________________________Relationship to Patient: __________ Phone #: _______________

~Name: ________________________________Relationship to Patient: __________ Phone #: _______________

Description of health care information to be released: ☐All

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Leave Appointment Messages:	**Leave Other Medical Information:**
☐Home phone (inc. auto call)	☐Home phone (inc. auto call)
☐Mobile phone (inc. auto call)	☐Mobile phone (inc. auto call)
☐Mobile text (inc. auto call)	☐Mobile text (inc. auto call)
☐With another person	☐With another person
☐Via email/portal	☐Via email/portal
• Via mail	€ Via mail

☐Patient received HIPAA Privacy Statement.

☐I give permission for Christian Health Service of Syracuse to import my medication history from pharmacy databases, when available.

Expiration date of this authorization: ___________________________

(This authorization expires upon release of requested information, unless otherwise stated.)

Signature: **Date:**

Print Name: ____________________ **Date of Birth:** ____________

Patient Name:	Patient Date of Birth:

Authorization of Additional Individuals to Access and/or Make Medical Decisions

I authorize Christian Health Service of Syracuse to use and disclose the specific health and medical information described below regarding the above-named patient.

Parent/Guardian Name: ______________________________ Relationship to Patient: __________ Initials:_____

The following individual is also a custodial parent/guardian of this patient:

Name: ____ Relationship to Patient: __________ Initials:_____

Copy of Court Order: ☐Yes ☐No

The following individuals are hereby authorized to act on my behalf to discuss and/or make medical decisions regarding the above-named patient:

Emergency Contact (Someone other than the parent whom we may call if unable to reach anyone else.)

First Name: _________________ Last Name: _____________________ Relationship to Patient: __________

Bring child to appt: Y / N Discuss patient information: Y / N Make medical decisions: Y / N Help us contact you: Y / N

Home Phone: ________________ Work Phone: _____________________ Cell Phone: ________________

Additional Authorized Individual

First Name: _________________ Last Name: _____________________ Relationship to Patient: __________

Bring child to appt: Y / N Discuss patient information: Y / N Make medical decisions: Y / N Help us contact you: Y / N

Home Phone: ________________ Work Phone: _____________________ Cell Phone: ________________

Additional Authorized Individual

First Name: _________________ Last Name: _____________________ Relationship to Patient: __________

Bring child to appt: Y / N Discuss patient information: Y / N Make medical decisions: Y / N Help us contact you: Y / N

Home Phone: ________________ Work Phone: _____________________ Cell Phone: ________________

We are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us. We cannot condition our provision of services or treatment to you upon the receipt of this signed Authorization. You may inspect a copy of the protected health information to be used or disclosed. You may refuse to sign this Authorization and at your request, we must provide you with a copy of the signed Authorization. You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier, or otherwise indicated, this Authorization will expire in 13 months from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under Federal Law.

Patient or Patient's Legal Representative (please print): ____
(Patients 18 years and older must sign for themselves unless other specific legal authority has been granted.)

Signature: ____**Date:** ____________________

Expiration 13 months from most recent initialed date. Date: _________ **Initials:** _____ **Date:** _________ **Initials:** _____

Address: ____

Phone: ____________________ Representative's Authority (e.g., parent, legal guardian, etc.): ______________________