



**Pediatric and Adolescent Medicine**  
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*Drs. Coleman, Thillairajah, & Greenberg, MD., LLC*

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Date Revoked: _____
Initials of Privacy Official _____

Patient Name: \_\_\_\_\_ Medical Record No.: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Healthcare Provider Name(s): \_\_\_\_\_

I authorize \_\_\_\_\_ to use or disclose my health information to \_\_\_\_\_ for the purpose of \_\_\_\_\_ in the manner described below.

1. **Dates of Service:** The following dates of service(s) to be used or disclosed:

<input type="checkbox"/> All dates of services
<input type="checkbox"/> For the date ranges of _____ to _____.
<input type="checkbox"/> For the following dates of services _____.

2. **Type of information:** The type of information to be used or disclosed for the dates indicated above is as follows (check the appropriate spaces and include other information where indicated):

<input type="checkbox"/> Entire medical record	<input type="checkbox"/> Entire billing record(s)
<input type="checkbox"/> Only the information indicated below:	
<input type="checkbox"/> Minimum Data Set	<input type="checkbox"/> Nursing documentation/progress notes
<input type="checkbox"/> Activity documentation	<input type="checkbox"/> Nutritional services documentation
<input type="checkbox"/> Assessments, flow sheets	<input type="checkbox"/> Physician and professional consult progress notes
<input type="checkbox"/> Business Office File	<input type="checkbox"/> Physician's orders
<input type="checkbox"/> Care Plan	<input type="checkbox"/> Rehabilitative and restorative therapy documentation
<input type="checkbox"/> Diagnostic reports (lab, x-ray, etc.)	<input type="checkbox"/> Social Services documentation
<input type="checkbox"/> History and physical, other hospital records	
<input type="checkbox"/> Medication and treatment records	
<input type="checkbox"/> Other: (Describe as specifically as possible) _____	
_____	

**Authorization Statements:**

- 3. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.
- 4. I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization, I must do so in writing and present my written revocation to the Healthcare Provider listed at the top of this Authorization. I understand that the revocation will not apply to information that has already been released in response to this Authorization.
- 5. Unless I specify differently, this authorization will expire within 160 days from the date of my signature. If you wish to specify a different expiration, insert date or event:\_\_\_\_\_.
- 6. I understand that Drs. Coleman, Thillairajah, & Greenberg, MD., LLC will not condition the provision of treatment or payment on the provision of this authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title of Personal Representative