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

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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:

____ All dates of services
____ For the date ranges of_____ to_____.
____ 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):

____ **Entire medical record**
____ **Entire billing record(s)**
____ **Only the information indicated below:**
____ Minimum Data Set
____ Activity documentation
____ Nursing documentation/progress notes
____ Assessments, flow sheets
____ Nutritional services documentation
____ Business Office File
____ Physician and professional consult progress notes
____ Care Plan
____ Physician's orders
____ Diagnostic reports (lab, x-ray, etc.)
____ Rehabilitative and restorative therapy documentation
____ History and physical, other hospital records
____ Social Services documentation
____ Medication and treatment records
____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