Orchard Pediatrics, PC

– Newborn through Adolescent Care –

Orchard Pediatrics, P.C. is authorized to use or disclose information about:

PATIENT NAME (please print): _____ **DATE OF BIRTH:** _____

PATIENT ADDRESS _____

1. The following *may receive disclosure* of protected health information:
   His/her/its name and address:

   _____

   _____

   _____

2. The specific information that should be disclosed is (please give dates of service if possible):

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED: **YES**, DISCLOSE THIS INFORMATION _____

NO, **DO NOT** DISCLOSE THIS INFORMATION _____

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

4. I may revoke this authorization by notifying Orchard Pediatrics in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

5. This authorization expires on _____, 200___, OR upon occurrence of this request.

We are interested in your reason for requesting your medical records to be transferred. Please check one of the following:

- ☐ Leaving the area (date of move_____)
- ☐ Transferring to another physician in the area
  Reason: _____
- ☐ Changing insurance
- ☐ Seeing a specialist on _____
- ☐ Other_____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You will be required to pre-pay for the copies.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that Patient must sign if 18 years of age

_____ _____

Signature of Parent, Guardian or Patient if 18 years of age Date