Premiere Pediatrics
530 Greensboro St.
Asheboro, NC 27203
Phone : 336-625-0500
Fax: 336-625-0509

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information

Name:_____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

I authorize Premiere Pediatrics to:

Release Information to: ***Obtain Information from:***

Name: _____ Name: _____
Address: _____ Address: _____
City, State, Zip Code: _____ City, State, Zip Code: _____
Phone # _____ Phone # _____
Fax # _____ Fax # _____

Purpose of request: _____

The following items must be initialed to be included in the use or disclosure of other health information:

___HIV/AIDS related health information and/or records.
___ Mental health information and/or records.
___ Genetic testing information and/or records.
___ Drug/alcohol diagnosis, treatment, and/or referral information.

Federal regulations require a description of how much and what kind of information is to be disclosed. _____
Except to the extent that action has already been taken in reliance upon this authorization. I understand that I may revoke this authorization at any t time by giving written notice to the medical records department. Unless revoked earlier, this authorization will ***expire 180 days from the date of signing*** or upon [insert application date or event of expiration]
_____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment options, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____
Signature of individual or Individual's Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Representative

_____
Staff Witness