Pediatric Practices of Northeastern Pennsylvania

1837 Fair Ave.	27B Woodlands Drive	62 Industrial Park Road
Honesdale, PA 18431	Waymart, PA 18472	Lake Ariel, PA 18436
Voice: 570-253-5838	570-488-9550	570-689-7565
Fax: 570-253-6678	570-488-9553	570-689-4803

Provider direct to our EHR may use direct-secure-messaging email address: ppnp@ppnp.pcc-direct.com

Patient Authorization to Use or Disclose Protected Health Information
Request for records *from* another physician or healthcare provider.

I, _____, understand Pediatric Practices of Northeastern
(parent, guardian, or patient if of age to consent)
Pennsylvania is authorized by me to request disclosure of my child's/ward (if appropriate) _____, _____ protected health information for
(patient name) **(date of birth)**
the purpose of **transferring medical records** for treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of _____ or any other individual listed
(physician, medical office or hospital to send PPNP records)
below to disclose my protected health information as described on this form to the office listed at the top of this form. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be requested *(check all that apply)*:

[ ] The patient's most recent medical records with summary of ongoing problems and complete immunization record.

Specific Information you desire to be sent

[ ] The patient's demographic information *(check all that apply)*:
[ ] Name [ ] Address [ ] State/Zip Code only [ ] Telephone
[ ] Age[ ] Gender [ ] Race [ ] Other: _____

[ ] Medical Data/Information as related to:
[ ] Specific condition(s): _____
[ ] Specific professional service(s): _____
[ ] Specific medication(s): _____
[ ] Other: _____

[ ] Other: _____
_____

[ ] The patient's entire medical record
(NOTE: This requires an explanation why the entire record may be disclosed .)

Name(s) or class of person(s) other than current employees or owner(s) authorized by this form to disclose the patient's protected health information: _____

SPECIAL AUTHORIZATION (If applicable)

Patient Initials	Parent/ Guardian Initials	**If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.**
_____	_____	Evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on the signed authorization.
_____	_____	Evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation information may be released to the recipient noted on the signed authorization.
_____	_____	Testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted on this signed authorization.

Pediatric Practices of Northeastern Pennsylvania is authorized to request information from:

_____

_____

Address or fax number where protected health information is to be requested from:

_____

_____

_____

Any other address or fax number is not permitted by this authorization.
The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Pediatric Practices of Northeastern Pennsylvania must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the parent or patient's (if appropriate) signature.

Pediatric Practices of Northeastern Pennsylvania will accept written revocations of this authorization via:
Certified U.S. mail or
Facsimile at this number: 570-253-6678

ALL revocations must be sent to Pediatric Practices of Northeastern Pennsylvania to the attention of the Security Manager, Linda Penwarden and are not effective until received by the Security Manager.

I also understand that this consent will expire one (1) year after the date of signature or automatically when the records requested on this authorization have been released (which ever occurs first). After this date, Pediatric Practices of Northeastern Pennsylvania can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____

Parent/Guardian/Patient's (if appropriate) Signature **Date**

Authorization added to the patient's medical record on _____.

Authorization verified by _____ on _____.