LITTLETON PEDIATRIC MEDICAL CENTER

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM LITTLETON PEDIATRIC MEDICAL CENTER.

Completion of this document authorizes the disclosure and/or the use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

Patient name:_____ Date of birth_____

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

1._____ 2._____

To provide health information from the above-named child's medical record to and from (list name and contact information for individuals receiving health information):

_____

_____

_____

_____

The disclosure is required for the following purpose:

_____

Requested information shall be limited to the following:

__ All minimum necessary health information

__Mental health related records

__Disease specific information as described_____

__ Other (specify)_____

DURATION: This authorization shall become effective immediately and shall remain in effect until_____ or for one year from the date of signature if no date entered.

YOUR RIGHTS: I understand that the following rights with respect to this Authorization: I may revoke the authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt but will not be effective to the extent that the Requestor or others have acted in reliance to this authorization.

I have a right to receive a copy of the authorization.

APPROVAL: _____

Printed name

_____ _____

Signature Date