Cascade Pediatrics

Authorization for Use or Disclosure of Protected Health Information

(18 yr Olds)

AUTHORIZATION FOR SPECIFIC CONFIDENTIAL COMMUNICATION

Is it ok to leave a detailed message including medical information on your voicemail? Yes _____ No _____ List Phone #: _____

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to (other than *parent/guardian*):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- ☐ Medical Care/Treatment Level of Information: _____
- ☐ Billing Information
- ☐ Pick up PHI (such as prescriptions, billing statements, labs, etc.)
- ☐ Other (Specify in detail – appointments: such as date of service, type of service, level of detail to be released, origin of information, etc.)

_____

_____

_____

_____

I specifically consent to the disclosure as indicated above that may contain the following information:

- ☐ Alcohol/Drug/Substance Abuse information _____ (initials)
- ☐ HIV test results or diagnosis of AIDS and AIDs related conditions _____ (initials)
- ☐ Mental Health information _____ (initials)
- ☐ Pregnancy information _____ (initials)
- ☐ Sexually transmitted diseases (STD) information _____ (initials)

This authorization shall be in force and effect and expires in 12 months or until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Cascade Pediatrics 5150 Cascade Rd SE, Suite B, Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Patient Name

_____ _____

Patient Signature Date