AUTHORIZATION FOR RELEASE OF INFORMATION BY PATIENT OVER 18 YEARS OLD

DESCRIPTION OF "PROTECTED HEALTH INFORMATION" TO BE USED OR DISCLOSED

I understand that it is the policy of SUBURBAN PEDIATRIC ASSOCIATES, INC. (the "Practice") to protect my privacy and to follow all state and federal privacy laws. However, I also understand that in order to **involve my parents or other individuals in my medical care** it may be necessary for the Practice to use/disclose some or all of my medical information ("Protected Health Information"). I hereby specifically authorize the Practice to disclose such information to the persons listed below:

I hereby authorize the disclosure of my Protected Health Information to the following individual(s):

Name: __________________________________ Relationship: _____________________________

Name: __________________________________ Relationship: _____________________________

PATIENT'S RIGHTS

I understand that I have the right to refuse to sign this Authorization to release my Protected Health Information. If I refuse to sign this Authorization, the Practice will in no way deny me my rights concerning treatment, payment for services, and enrollment in a health plan or eligibility for benefits.

I understand that I may revoke this Authorization at any time after I have signed it by providing the Practice Manager and the Practice's Privacy Officer, with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my Protected Health Information will no longer be used / disclosed pursuant to this Authorization except when **medically necessary in an emergency situation.**

I specifically authorize the disclosure of my Protected Health Information as set forth in this Authorization. I understand that if my Protected Health Information is disclosed, then this information may be subject to re-disclosure by the recipient and may no longer be protected by the federal patient privacy laws. For example, the recipient may request that Protected Health Information be provided to a school or camp.

This Authorization, unless I earlier revoke it, shall remain in effect for **as long as I am a patient at the Practice.**

**** I hereby authorize my parent(s) or any above authorized individual, to access my medical records including the Patient Portal:

Patient's Signature: _______________________________ Patient Date of Birth: ________________

Patient Name **(Print)**: ______________________________ Patient Phone # ____________________

Date: ________________________ **Patient's Email** ____

ONLY fill in this box if you are refusing to authorize.

Form Presented to Patient on ________________. Patient REFUSES to provide authorization.
(Date)

Name: ______________________________ **Signature:**___________________________________

Mason-9600 Children's Dr. Mason, OH 45040 * Liberty- 7335 Yankee Rd. Liberty Twp, OH 45044
Forest Park- 752 Waycross Rd. Cincinnati, OH 45240