

Corbin Pediatric Associates, PSC
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London, KY 40741
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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
(First) (Middle) (Last)

I, _____, hereby authorize Corbin Pediatric Associates, PSC. to:
____ use and/or disclose protected health information described below to _____
(the name of entity to receive information)
at _____; or
(address)
____ to receive protected health information described below from _____
(the name of entity to send information)
at _____.

My protected health information will be used or disclosed upon request for the following purposes [please name and explain each purpose]:

____ At request of patient (or Personal Representative)

____ (other, please specify) _____

This authorization for use and/or disclosure applies to the information described below [mark those that apply]:

- ____ Any and all records in the possession of [Name of physician practice] including mental health, HIV, and/or substance abuse records. [Cross out any item you do not authorize to be released].
- ____ Records regarding treatment for the following condition or injury _____ on or about _____.
- ____ Records covering the period of time _____ to _____.
- ____ Other [please specify - include dates] _____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office's Privacy Contact or the Office Manager at Corbin Pediatric Associates, 60 Bryan Boulevard, Suite 200, Corbin, KY 40701. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Corbin Pediatric Associates may not condition treatment or payment on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on [please list a specific date or event] _____. This authorization will automatically expire one (1) year from the signature date stated below. I certify that I have received a copy of this authorization.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative
Authorization for ROI cpa
Rev 110102

Relationship to Patient