AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

FAIRFAX PEDIATRIC ASSOCIATES

I authorize the use / disclosure of health information about me as described below

Patient Name:_____

Please Print Name

Patient's Date of Birth:_____

A. Person(s) or Organization(s) authorized to receive the information:

( ) MOTHER_____

( )FATHER_____

( )FAMILY MEMBERS (LIST NAMES)

_____ _____ _____

( )OTHER

_____

B. Specific description of the information that may be used or disclosed (including dates):

( ) IMMUNIZATIONS

( )FULL MEDICAL INFORMATION

C. Specific description of how the information will be used:

1) I understand that this authorization will **expire** one year from todays date.
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying (*FAIRFAX PEDIATRIC ASSOCIATES)* in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that, if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient