

ANGEL PEDIATRICS, PA

PF-3000 Standard Authorization of Use and Disclosure of Protected Health Information

Persons Authorized to Use and Disclose Information

Information listed below will be used and disclosed by: Angela Asom, MD

Persons to Whom Information May be Disclosed

Information described above may be disclosed to:

(list name of person(s)organization(s): _____

Purpose of Disclosure

Information below will be disclosed to the following purposes:

education, discussion of treatment plan, medical decision making or

(list) _____

Information to be used or disclosed

The information covered by this authorization includes:

all information in my files or

(list) _____

Expiration Date of Authorization

This authorization is effective unless **until revoked** by the patient or the patient's representative.

Right to Terminate Authorization

You may revoke or terminate this authorization by submitting a written revocation to the practice. You should contact the **Privacy Officer** to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure the your right to the protection of the privacy of this information once our practice discloses it to another party.

Rights of the Individual

You may **inspect** or **copy** information used or disclosed under this authorization. You may **refuse to sign** this authorization.

Effect of Refusing Authorization

If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including: Treatment conditioned on authorization.

Name of patient (Print or Type): _____ Date: ____-____-____

Signature Patient / Representative: _____ Relationship): _____

List any person or organization you would like to have access to your child's medical health information. Ex: relative, nanny, friend, daycare. **If you leave this form blank, we will not be able to release information to anyone other than you.**