

GREATER LOWELL PEDIATRICS

Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name: _____ Date of Birth: ___/___/___

I hereby authorize: _____

to use and/or disclose the Protected Health Information described below to (Entity to whom information is being released): GREATER LOWELL PEDIATRICS, INC.

for the purpose(s) of (specify the reason that this information is being released):

Protected Health Information (Identify specific information to be released):

Dates of care included: _____ to _____

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that GREATER LOWELL PEDIATRICS will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of GREATER LOWELL PEDIATRICS. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

EXPIRATION DATE OR EVENT: This authorization will expire on (date no later than one year from now) _____, or the following event:

(If no date is stated, this authorization expires six months from the date it was signed.)

