BROWNSBORO PARK PEDIATRICS

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name_____ Date of Birth _____

Address _____

City _____ State_____ Zip Code _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *I authorize the release of medical information to the insurance company for the purpose of determining and receiving benefits for medical bills. I understand that claims will be submitted to my insurance company on me behalf. I further understand that I am responsible for any amount of medical bills not covered by my insurance policy, this included copays, coinsurance, deductible, and non-covered services.*
3. *I authorize the use of telehealth as a means of medical care when suggested by my physician. I understand the potential risk to this form of technology, including interruptions, unauthorized access, and technical difficulties. I further give permission for this style of visit to be billed to my insurance and I assume responsibility for any charges not covered by my insurance carrier.*
4. *I agree to immunize my child as directed by the doctors of Brownsboro Park Pediatrics and recommendations of the American Academy of Pediatrics vaccine schedule. This policy will require my child to be up to date on his/her immunizations no later than 2 years of age.*
5. *The following individuals are authorized to obtain information and/or accompany my child to any doctor visits (Must be over the age of 18 years)*

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

6. The type and amount of information to be used or disclosed is as follows:

_____Complete health records
_____Physical exam
_____ Immunization record
_____All
_____Lab/Imaging results
_____Consultation reports
_____Bills/Account Balances

_____ Other (please specify)

_____

7. The forms of contact that is information may be disclosed in is as follows:

_____ Phone _____ Voicemail _____ Email _____ Fax

8. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
9. I understand that authorizing the discloser of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assume treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____ _____
Signature of patient or legal representative Relationship Today's Date