Capote Pediatrics
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WWW.CAPOTEPEDIATRICS.COM

Privacy Authorization Form

Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I, _____ authorize Capote Pediatrics
(Your name)

to use and disclose the protected information described below to:

_____
(Name of parent or persons who can access your medical records)

PICK ONE OPTION:

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release of my complete health record, **EXCEPT** for:

☐ Mental Health
☐ Sexual Health
☐ Other Lab Results
☐ Alcohol/Drug Abuse Treatment
☐ Other (please specify):_____

- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
(Patient Signature) (Date)

_____
(Patient Phone Number)

_____
(Patient Email)