1115 Ronald Reagan Parkway, Suite 136, Avon, IN 46123 • (Phone) 317-217-2900 (Fax) 317-217-2909

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT'S NAME		DATE OF BIRTH
STREET ADDRESS		CITY, STATE, ZIP
PHONE NUMBER	SECONDARY PHONE NUMBER	

I hereby authorize PEDIATRIC ASSOCIATES OF AVON to release my child's health information TO:

NAME OF AGENCY/FACILITY OR INDIVIDUAL(S)	
STREET ADDRESS	PHONE
CITY, STATE, ZIP	FAX

Health Information to be Released:

☐ Itemized Bill	☐ Office Visits/Progress Notes	☐ Pathology, Labs, Imaging Reports
☐ Operative/Procedure Reports	☐ Entire Record	☐ Specific Dates:

Purpose of Release:

☐ Personal Use	☐ Transfer of Care	☐ Insurance	☐ Legal	☐ Other (Specify):

Release Method and Applicable Fees:

$25 flat fee (includes supplies, labor and postage)	☐ Mail	☐ Pick up	☐ Fax (Max. 40 pages)

(Third Party Requests: Postage **plus** $1 per page for the first 10 pages, $0.50 for pages 11-50, $0.25 for pages 51+.)
(**NO charge** if transferring due to new Medicaid coverage)

- This authorization will expire 60 days from the date signed unless otherwise specified (not to exceed 180 days): ____
- I understand that I have the right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing and present my written revocation to Pediatric Associates of Avon. The revocation will not apply to information that has already been released in response to this authorization.
- I understand that I am not required to sign this Authorization in order to receive health care treatment.
- Pediatric Associates of Avon's records may include records that were received from other organizations. If these records have been used by Pediatric Associates of Avon, and filed in the record of Pediatric Associates of Avon, these records may be released with your Pediatric Associates of Avon records.
- Pediatric Associates of Avon cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by the state and federal privacy protections after it is released. By signing this authorization, you release Pediatric Associates of Avon from any and all liability resulting from a redisclosure by the recipient.
- Fees assessed cover the cost of materials, labor and postage as defined by HIPAA and highlighted by the Omnibus Final Rule.

Your signature indicates that you have read and understood this form, you authorize the release of your information as described above, and agree to pay any fee(s) due. Please allow 1-2 weeks for processing.

____ ____________________

Patient or Legal Guardian Signature Date

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Relationship to Patient / Authority to Act on Patient's Behalf (Attach documentation)