Dover Pediatrics, PLLC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

This authorization is for use or disclosure of protected health information pertaining to:

Requester's Name: _____ Patient: _____

Address:_____

Child's DOB : _____ Daytime Phone: _____

I hereby authorize:

□ *Dover Pediatrics, PLLC 17 Old Rollinsford Rd., Ste 5 Dover, NH 03820 P: (603) 742-4048; F: (603)743-3345*

□ Other:_____

To release my protected health information to: □ **Dover Pediatrics, PLLC - or -** □ **Other** *(list below)*

Name:_____

Address: _____

Purpose of disclosure:

□ Transferring care **FROM** Dover Pediatrics Reason for Transfer: _____

□ *Transferring care **TO** Dover Pediatrics, PLLC*

Protected health information to be released:

□ Medical records: □ All Records - or- □ Records for Date Range: _____ to _____

□ Billing records - with Time frame: □ Entire Record - or- □ Records for Date Range _____ to_____

Your specific permission is required to disclose information regarding the following: *Check box to specify protected health information to be disclosed.*

□ Treatment by Mental Health Professional or Program _____

□ Drug/Alcohol Abuse _____ □ Genetic Testing _____

□ HIV Test Results or Status _____ (Maine state law requires practices to inform you that, if this information is misused, disclosing your HIV infection status may have consequences, such as negative treatment in your personal life or by insurance companies. It can be important for providing you needed services & healthcare.)

- I understand that I am not required to sign this form and Dover Pediatrics, PLLC will not render and/or condition treatment, payment for services, or eligibility for services on whether I sign this form. I understand that my refusal to sign may result in improper diagnosis or treatment, denial of coverage for health benefits or other insurance or other adverse consequences.
- I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.
- I understand that I have the right to access or copy the PHI described in this form by making a written request to the attention of the Privacy Officer of this practice. ***A copying fee may be charged as permitted by law***.
- I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken in reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer at Dover Pediatrics, PLLC. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.
- I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by confidentiality laws.
- I understand that PHI that includes alcohol or drug program information protected by federal law will require notice to the person receiving the information that it may not be shown to or shared with others without my express written permission.
- I understand that I have a right to receive a copy of this authorization.

Signed_____ Date: _____

Print name: _____

If signed by anyone other than patient, indicate legal relationship: _____

Method of Delivery: □ Mail to receiving entity above □ **I will pick up** □ **Designee will pick up (specify)** _____

Photo identification is required when picking up medical records.

This authorization becomes effective immediately and shall expire one (1) year from signature date.