

South County Pediatric Associates, PC
Authorization for Release of Protected Health Information

Name of Individual/Other Name Used

Birth Date

Street Address

City, State, Zip, Phone

AUTHORIZES:

RELEASE OF PROTECTED HEALTH INFORMATION TO:

South County Pediatric Associates, PC
4850 Lemay Ferry Rd
Suite 120
Saint Louis, Missouri 63129
314-849-3320
Fax: 314-849-7766

Individual/agency/organization making disclosure

Street Address

City, State, Zip Code, Phone

INFORMATION TO BE RELEASED:

The following is a specific description of the health information I authorize to be used and/or disclosed (please be specific regarding information you want released): _____

In compliance with Missouri Statutes, which require special permission to release otherwise privileged information please release records pertaining to: [Check all that apply]

- Mental Health Alcohol &/or Drug Abuse HIV Test Results
 Other (Specify): _____

For the Following Date(s): From _____ to _____.

PURPOSE OF AUTHORIZATION: (Check applicable categories)

- Transfer Records Further Medical Care Coordinating Care for Child Insurance Eligibility/Benefits
 Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization – I understand that if I sign this authorization, I may request a copy of this authorization.

Right to Withdraw This Authorization – I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to South County Pediatric Associates, PC. I am aware that my withdrawal will not be effective until received by South County Pediatric Associates, PC and will not be effective regarding the uses and/or disclosures of my health information that South County Pediatric Associates, PC has made prior to receipt of my withdrawal statement.

RE-DISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicate date or event) _____. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PARENT/GUARDIAN: _____ **DATE:** _____
(Note: if signed by guardian, copy of legal guardianship papers required)