Protected Health Information Authorization form

Growing Bones Pediatric & Neuromuscular Orthopaedic Institute

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Growing Bones Pediatric & Neuromuscular Orthopaedic Institute** to use and/or disclose certain protected health information (PHI) about me to the defined individuals. (Please refer to privacy practices)

This authorization permits **Growing Bones Pediatric & Neuromuscular Orthopaedic Institute** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

If disclosure is requested by the patient, purpose may be listed as “at the request of the individual.”)

- ☐ At the request of the individual
- ☐ Medical Care
- ☐ Legal Request
- ☐ Other ____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire 1 year following the date of authorization

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Growing Bones Pediatric & Neuromuscular Orthopaedic Institute**. In fact, I have the right to refuse to sign

this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Growing Bones Pediatric & Neuromuscular Orthopaedic Institute

1057 South Bradford Street

Dover, DE 19904

Family, Friends, and Specific Individuals:
I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial insurance, and billing information with those listed below. I understand that my or my child's healthcare provider will use his judgement in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPPA compliant authorization. The permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

Name	**Relationship To Patient**
1. ______________________________	__________________
2. ______________________________	__________________
3. ______________________________	__________________
4. ______________________________	__________________

	YES	NO
The practice staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during appointment		
The practice staff have my permission to leave messages concerning treatment		
The practice staff have my permission to communicate with the school nurse about details of my child's medical condition		

Copyright © 2020 by the American Academy of Family Physicians. All rights reserved.

PHI SHOULD NOT BE RELEASED TO THE FOLLOWING INDIVIDUALS:

Name	**Relationship To Patient**
1. ______________________________	________________
2. ______________________________	________________

Patient / Parental Acknowledgement:

Signed by: ____________________________ ____________________
Signature of Patient or Legal Guardian Relationship to Patient

____________________________ ____________________
Print Patient's Name Date

____
Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

Copyright © 2002 Gates, Moore & Company.

Copyright © 2020 by the American Academy of Family Physicians. All rights reserved.