COASTAL PEDIATRIC ASSOCIATES

Authorization/Disclosure Form

The purpose of this authorization is to meet the patient's request for information disclosures and uses. This authorization form permits Coastal Pediatric Associates (CPA) to use or disclose protected health information listed below to the individuals or organization listed for the following patient:

Patient Name _____ *Date of Birth*_____

This authorization shall be enforced until revoked by the patient, parent, legal guardian, or personal representative (as defined by HIPAA).

Please provide the front desk with a copy of any legal paperwork describing guardianship or financial responsibility if other than the biological parent(s). Please note that both biological parents are legally entitled to receive medical information on a minor unless otherwise ruled by the Judicial System and documentation is presented to CPA. Once the minor reaches 18 years of age he/she will be required to complete all patient paperwork unless otherwise stated by the Judicial System with proper documentation presented to CPA.

Please list two phone numbers with voicemail where CPA may leave a message or send text messages pertaining to appointments, financial or insurance details, and clinical information.

Primary:	Secondary:

With my permission, I hereby authorize the following individual(s):

Name or Organization:	Relationship to Patient:	Contact Phone Number:

to consent to any and all medical care and attention for this child in which is deemed necessary and appropriate by a healthcare provider at CPA. This consent includes, but is not limited to, emergency services, lab tests, procedures and immunizations. The listed individuals are given the authority to discuss and change appointments, financial or insurance details, and clinical information including lab results.

By verifying the identity of the individual calling, I give Coastal Pediatric Associates the authority to send vaccination records via fax or e-mail to specified daycare centers, schools, or other health care facilities once verbally requested. Verification information will include, but is not limited to: patient's address, phone numbers, insurance, and appointment information.

I understand that I have the right to refuse to sign this authorization and that treatment will not be conditioned on signing. I understand that I have the right to revoke this authorization at any time by sending a written notification to the practice. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient, Parent, Legal Guardian (include court documentation), or Personal Representative (as defined by HIPAA):

Signature	**Print Name**	**Date**

Description of Personal Representative's Authority (attach documentation, if necessary):

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Office Use Only: Receiving Employee _____ Date Received _____

☐ Copy given to Patient