PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

By signing this authorization, I authorize **Hirsch Pediatrics** to use and/or disclose certain protected health information (PHI) about me to the following entity:
_____.

This authorization permits **Hirsch Pediatrics** to use and/or disclose the following individually identifiable health information about me (specify 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 (Note: If requested by the patient, purpose may be listed as "at the request of the individual."):
_____.

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 on (give expiration date or defined event):
_____.

The Practice will ___ 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 **Hirsch Pediatrics**. 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 **Steven Hirsch, MD, Privacy Official, at 15235 Shady Grove Road, Suite 105, Rockville, MD 20850**.

_____	_____	_____
Date	Signature of Legal Guardian (or patient)	Print name of Legal Guardian (or patient)
	_____	_____ **parent**
	Patient Name	Relationship to Patient