HIRSCH
PEDIATRICS

# MENTAL HEALTH/THEARPY

## 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 MENTAL HEALTH/THERAPY GROUP:

Name of person:

_____

Name of organization:

_____

This authorization permits **Hirsch Pediatrics** to use and/or disclose any and all individually identifiable health information about me related to **ONGOING MENTAL HEALTH/THERAPY CONCERNS.**

The information will be used or disclosed at the request of the parent, guardian, or patient. This authorization will expire when upon my written notice or on the following date (enter date _____).

Hirsch Pediatrics 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) |
| | _____ | _____ |
| | Patient Name | Relationship to Patient |