FOREST HILLS PEDIATRICS, LLC

HIPPA AUTHORIZATION FORM

Authorization for Use or Disclosure of Information for Purposes Requested by Physician Office.

I, _____herby authorize Forest Hills pediatrics, LLC to: use and/or disclose any protected health information (e.g. immunization records, lab reports, child's health status, etc.) to following entities via telephone/fax/mail:

_____ school/daycare/babysitter

_____ other health care providers
(E.g. pharmacies, labs, hospitals, specialist)

_____ Insurance companies

Any exclusion? _____

_____ Okay to leave messages at home? _____ Okay to leave messages at work

This authorization shall be in force and effect for 365 days from today's date at which time this authorization to use or disclose this protected health information expires. **THIS DOCUMENT APPLIES TO ALL FAMILY MEMBERS UNDER OUR CARE UNLESS OTHERWISE DESIGNATED BY THE RESPONSIBLE PARTY.**

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Forest Hills Pediatrics, LLC. I understand that a revocation is not effective to the extent that FHP has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Forest Hills Pediatrics, LLC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for requested use of disclosure.

I understand that I have the right to

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights)
- Refuse to sign the authorization

The use of disclosure requested under this authorization may result in direct or indirect remuneration to FHP from a third party (if applicable).

_____ _____ _____
Signature of Patient or Responsible Party | Printed Name of Responsible Party | Date

CHILD'S NAME	BIRTH DATE

Relationship to Patients: _____