HIPAA AUTHORIZATION FORM

I authorize **Chapin Pediatrics, PA** to use and disclose my *protected health information* (PHI) listed below upon my request. This includes faxing this information to designated entities or persons.

_____Appointments _____Restrictions _____Medications _____Released from care

_____Date of visit _____Reason for visits _____Diagnosis

Entity or person(s) authorized to receive this information:

_____School/Daycare/Preschool _____Camp _____Employer _____Social Worker

_____Personal Representative's Employer _____Truant Officer _____Parole Officer

_____Family/Friends

This PHI is being used or disclosed for the following purposes:

____Work/School Excuse _____To verify restrictions _____Verify return to work/school

This authorization shall be in force and effect until the time or event specified below, at which time this authorization to use and disclose this PHI information expires.

_____No longer in school ____Employment terminated _____Released from care

_____Child reaches age of majority

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at *info@chapinpediatrics.com* or *119 Amicks Ferry Road Chapin, South Carolina 29036*. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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

______________________________________ ______________________________________
Signature of Patient or Personal Representative Date

______________________________________ ______________________________________
Print Name of Patient or Personal Representative Personal Representative's Authority

(Provide a signed copy of this form to the patient.)