



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.)