HIPAA NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____

1. Beittel-Becker Pediatric Associates has made the Notice of Privacy Practices available to me.

2. Beittel-Becker Pediatric Associates may access, collect, use and disclose my health information to my primary care or referring physician, to consultants, and as necessary to others to process insurance claims, insurance applications and prescriptions.

3. Beittel-Becker Pediatric Associates may also disclose my health information these persons:

Name: _____ Phone: (_____) _____Relationship to the Patient: _____

Name: _____ Phone: (_____) _____ Relationship to the Patient: _____

3. Beittel-Becker Pediatric Associates **may release my complete health record** (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse, if any), **unless indicated below**:

□ Beittel-Becker Pediatric Associates **may not** release mental health records
□ Beittel-Becker Pediatric Associates **may not** release record containing communicable diseases (including HIV and AIDS)
□ Beittel-Becker Pediatric Associates **may not** release records containing alcohol/drug abuse treatment
□ Beittel-Becker Pediatric Associates **may not** release other records (please specify):

_____

4. This authorization is effective for all of my records, including past records, and remains in effect until it is revoked in writing, unless a date is specified here: _____

5. Beittel-Becker Pediatric Associates may provide me with information on activities and developments and may disclose my information to third parties who help Beittel-Becker Pediatric Associates to inform me. This authorization expires 3 years after my last appointment.

6. I may revoke this authorization, in writing, at any time. This would not be effective to the extent that anyone has already relied on it, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. My treatment, payment, enrollment, or eligibility for benefits is **not** be conditioned on this authorization.

8. I understand that my information may be disclosed by a third-party recipient and may no longer be protected by federal or state law.

SIGNATURE

I have provided all of the required information for this form and note that it is accurate and complete. I also understand and agree to adhere to the provisions as outlined.

_____ _____/_____/_____
Patient Signature Date

OR

_____ _____/_____/_____
Responsible Party Signature Date

_____
Relationship to Patient