TWELVE CORNERS PEDIATRICS

PATIENT AUTHORIZATION FOR TWELVE CORNERS PEDIATRICS
TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Twelve Corners Pediatrics to use and/ or disclose protected health information (PHI) about me to the party or parties listed below.

This authorization permits Twelve Corners Pediatrics to use and/ or disclose my individually identifiable health information to _____.
If the information to be disclosed is to be restricted, please list specifics such as date (s) of service, type of service (s), or diagnosis, etc.
_____

_____

This authorization will expire on _____ .

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 Twelve Corners Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

Twelve Corners Pediatrics
1815 South Clinton Avenue Suite 310
Rochester, New York 14618

Signed by: _____
Signed by patient or Legal Guardian Relationship to Patient

_____
Patient's Name's Date

_____