



PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Potomac Pediatrics, P.C. to use and/or disclose certain protected health information (PHI) about me. This authorization permits Potomac Pediatrics, P.C. to use and/or disclose individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information may be used or disclosed for the following purposes:

- Medical Clearance (school forms, camp forms, etc)
- Return to Work/School
- Medical Record Release
- Other Issues:

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Potomac Pediatrics, P.C. In fact, I have the right to refuse to sign this authorization. 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 the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Amy Kaplan, M.D., Privacy Officer 9715 Medical Center Drive, Suite 230, Rockville, Maryland 20850 301.279.6750

Signature of Parent or Guardian

Date

Relationship to Patient

Patient's Name

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

For Office Use Only:

Date Received: _____ By: _____

Fee: _____ Form of Delivery: _____

Effective Date: April 14, 2003