PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

Coeur d'Alene Pediatrics

By signing this authorization, I authorize Coeur d'Alene Pediatrics to use and/or disclose certain protected health information (PHI) about myself/my child to or for the party or parties listed below.

This authorization permits Coeur d'Alene Pediatrics to use or disclose to_____

_____

Person or Entity to Receive the information

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)

_____

_____

_____

_____

_____

This authorization will expire on_____.

(Expiration Date or Defined Event)

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 Coeur d'Alene Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to the Coeur d'Alene Pediatrics Privacy Officer at 700 W. Ironwood Drive, Suite 102, Coeur d'Alene, Idaho 83814.

Signed by:_____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient's Name — Date

_____

Print Name of Patient and/or Legal Guardian