Authorization for Use/Disclosure of Health Information for Patients 18 Years and Older

Patient's Name: _____ Patient's DOB: _____

Patient's Email: _____ Patient's Cell: _____

Please check one:

☐ I **do not give permission** to discuss my medical history with anyone, including my parents.
If you checked this box, go directly to page 2 for signature of patient.

-- OR --

☐ **I do give permission** to the following people to receive information:
You can list people such as your parents, another doctor, or your school. They must be 18 years of age or older.

First Name	Last Name	Phone Number
First Name	Last Name	Phone Number
First Name	Last Name	Phone Number

You have the right to limit the type of information released from your medical records, as in the case of HIV test results, mental health information, and alcohol and drug abuse information.

Please check one:

☐ **I have no limitations on the information to be released from my medical record to the individuals listed above.** This includes information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation: x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol, or other controlled substance information, billing information, correspondence, and records from my other health care providers that Tenth Street Pediatrics may hold.

-- OR --

☐ **I do have limitations.** The following information is not to be released from my medical record to anyone:

_____ Last physical exam visit
_____ Last sick visit
_____ Prescriptions
_____ Radiology
_____ Other information not to be released: _____
_____ Referrals to another doctor, psychologist, etc.
_____ Medical treatment plan
_____ Lab results

Tenth Street Pediatric Medical Group, Inc.
1450 10th Street, Suite 304 – Santa Monica, CA 90401
Tel: (310) 458-1714 – Fax: (310) 394-8754

Redisclosure

I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to Sign/Right to Revoke

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation

I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice.

Questions

I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have the right to receive a copy of this Authorization from my health care provider.

Photocopy

A photocopy, fax, or electronic copy of this Authorization shall be considered as effective and as valid as the original.

Term

This Authorization will remain in effect for one (1) year from the date this Authorization is signed.

Do you grant permission for your parents to access your online patient portal (Healow)?

This includes information such as growth charts, list of appointments, and immunization history.

☐ YES ☐ NO

Please sign below:

_____ _____

Signature of Patient **Printed Name of Patient**

Date **Signature of Witness**

If individual is unable to sign this Authorization, please complete the information below:

_____ _____

Signature of Representative **Printed Name of Representative**

_____ _____ _____

Date **Legal Relationship** **Signature of Witness**

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