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Kitty Dessenberger, R.N., C.P.N.P.
Stacey A. Toben, M.S., R.N., C.P.N.P.
Sylvia Matherly, R.N., M.S., C.P.N.P.
Sheri Caiafa, Administrator

Northwest Clinic for Children, P.A.

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I, _____, hereby authorize Northwest Clinic for Children to use or disclose protected health information relating to the health records and information pertaining to, medical history, mental and/or physical condition, and services rendered to:

Patient Name _____ Date of Birth _____

Address_____ Phone_____

The protected health information and photocopies of medical records concerning the above named patient may be released:

FROM: **TO:**

_____ _____

_____ _____

_____ _____

The protected health information is being used or disclosed for the following purposes:

_____

Please check one: ❑ Entire medical record ❑ The following described records only *(specific types & dates)*

_____

I understand this may include information relating to AIDS, HIV Infection, Psychiatric Care, and/or treatment for alcohol and/or drug treatment.

I understand this authorization may be revoked in writing at any time, according to the instructions in the NWCC Notice of Privacy Practices and Procedures, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire sixty (60) days from the date of this authorization.

I further understand that I have a right to receive a copy of this authorization.

_____ _____

Signature of Patient/Personal Representative Date

_____ _____

Print Name of Patient/Personal Representative Relationship to PT

Records prepared and transmitted by:_____ Date_____