PLATTSBURGH PRIMARY CARE PEDIATRICS

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Patient Authorization Form

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below

Patient Name:______________________________ Date of Birth:______________
Patient Name:______________________________ Date of Birth:______________
Patient Name:______________________________ Date of Birth:______________
Patient Name:______________________________ Date of Birth:______________

Description of the specific information to be discussed or released:

- ☐ Written Prescriptions
- ☐ Medications
- ☐ Appointment date/time
- ☐ Diagnosis
- ☐ Imaging/Lab/Test results
- ☐ Summary of Medical Record
- ☐ Care Plan
- ☐ May schedule/bring to appointments
- ☐ May authorize Immunizations
- ☐ Other________________

Indicate confidential information:

- ☐ Mental Health
- ☐ HIV information
- ☐ Alcohol/Drug information
- ☐ Other ________________

Information to be given/shared with the following person/organization

Name: ______________________________ Relationship:____________
Name: ______________________________ Relationship:____________
Organization:______________________________ Relationship:____________
Organization:______________________________ Relationship:____________

This authorization shall remain in effect from the date below until (please check one):
☐ Expiration date (please specify)__________ ☐ No Expiration date

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office, attention Administrator
- This authorization is giving Plattsburgh Primary Care Pediatrics the right to disclose or release my medical information with the one or more people/organizations listed above.

Signature: ______________________________ Date:______________

Relationship to patient (If signed by personal representative of patient)______________________________