

Derry Pediatrics 43B Birch St Derry NH 03038

Phone (603) 434-0327 FAX (603) 437-7175 AUTORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

| Pa | atient Name | DOB |
|-------------|--|--|
| Pa | arent/Guardian | Relationship |
| bel re- | low. I understand that whe disclosure by the recipier | understand that my/my child's medical record contains protected health is has kept the information in the medical record in strict confidence. I specifically authorize any of Derry Pediatrics to disclose protected health information as described below to the recipient listed en this information is used or disclosed pursuant to this authorization, it may be subject to t. Derry Pediatrics cannot be responsible for how this information is used once it is released. RMITS DERRY PEDIATRICS TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION DISTED BELOW: |
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| | | ect or obtain a copy of the protected health information described by this authorization. |
| l un And | derstand that Derry Pedi I that I may refuse to sign | atrics will not condition treatment on my providing authorization for the request, use, or disclosure this authorization. |
| טוט | reity rediatrics. I also und | ske this authorization in writing at any time by delivering such written revocation to the Privacy Officer lerstand that such revocation will not be effective as to the disclosure of records whose release I have re action has already been taken in reliance on an authorization I have signed. |
| Desc | cription of information to | be disclosed. Check all that apply: |
|) | Patient demographic in | formation, name date of birth, address, telephone, etc. |
|) | Complete Medical Reco | rd |
|) | Laboratory/Test results | only |
|) | Immunizations record o | nly |
|) | Information relating to | specific health condition. Please specify. |