8752 Union Centre Blvd.
West Chester, OH 45069

800 Compton Rd, Suite 25
Cincinnati, OH 45231

# Pediatric Care, Inc.

## Authorization to Disclose Protected Health Information

- I understand that it is the policy of Pediatric Care, Inc. to protect the privacy of all patients and to follow all state and federal patient privacy laws.
- I understand that I have the right to refuse to authorize Pediatric Care, Inc. to release my Protected Health Information.
- I understand that if my Protected Health Information is disclosed, then this information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.
- I understand that this authorization is in effect for as long as I am a patient at Pediatric Care, Inc. unless I choose to revoke it earlier in writing.
- I understand that I may revoke this authorization at any time by submitting a written statement to Pediatric Care, Inc.

**Select <u>One</u> Option Below:**

_____ I hereby authorize Pediatric Care, Inc. to disclose medical information and billing information about myself to my parent(s) or guardian(s.)
Name(s) of Authorized Person(s): _____
_____

_____ I DO NOT authorize Pediatric Care, Inc. to disclose any Protected Health Information to anyone other than myself.

_____ _____
Patient's Printed Name Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Patient's Cell Number Patient's Email