# *Pediatric Associates Of Lafayette, P.C.*

## PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION

By signing this form, I authorize Pediatric Associates Of Lafayette, P.C. to disclose certain protected health information (PHI) about my child. This authorization permits Pediatric Associates Of Lafayette, P.C. to disclose the following individually identifiable health information:

- ☐ Immunization Records
- ☐ Health Forms
- ☐ Sports Forms
- ☐ Medication Forms
- ☐ Other: (Must be specific) _____

The individually identifiable health information will be:

- ☐ Picked up by parent
- ☐ Picked up by another adult (must be specific)_____
- ☐ Mailed to child's home (addressed envelop must be provided)

***This authorization will expire 60 days from the date of the signature below.(Indiana State Law IC 16-39—1(e) states an authorization is valid for 60 days after the date the request is made.)***

I understand that when the information is disclosed according to this authorization, it may be re-disclosed by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that Pediatric Associates Of Lafayette, P.C. has already acted in reliance upon this authorization.

**Patient's Name:** _____ **Date of Birth:** _____

**Address of Patient:** _____

**Signature of Parent or Legal Guardian:** _____

**Printed Name of Parent or Legal Guardian:** _____

**Date:** _____

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FOR OFFICE USE ONLY: _____

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