molly rad M.D. PEDIATRICS

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

Name:_____	MR#_____

I understand that Dr. Molly Rad Pediatrics will not condition treatment,' payment, enrollment or eligibility for benefits on my providing or refusing to provide authorization.

I hereby authorize:

Name of disclosing party _____

Address_____

City State Zip

To disclose to:

Name of recipient _____

Address_____

City State Zip

Records and information pertaining to _____

Name of member/patient MR # Date of Birth

Address _____Daytime Telephone

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different sate if specified.

Revocation: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by-law.

Specify Check the box and initial to specify which type of information is to be disclosed

Records ☐ Medical Information_____ ☐ Physical Information

☐ Drug/Alcohol Information ☐ HIV Test Results

Other Information_____

_____ _____

Signature Date

The recipient may use the health information authorized on this form for the following purposes:

_____

Date: _____ Signature: _____

If signed by other member/patient/party, please indicate relationship and cause:

_____