Newport Pediatrics, P.C.
1829 Crowe Lane
Newport ,TN 37821

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Patient Authorization for Use/Disclosure of Health Care Information

Patient Name: ______________________ Date of Birth: __________
Address: __________________________ SSN: ______________
____

I request and authorize ______________________________ to release health care
(Name and fax number of Physician or entity information is being disclosed by)
information of the patient named above to:

Newport Pediatrics, P.C.
1829 Crowe Lane
Newport, TN 37821
Fax Number: (423) 625-8264

This request and authorization applies to: Initials

- Only records generated by this facility_______________ ______
  (Not including records received from other sources)
- Only some portion of records maintained at this facility_____ ______
  These dates of treatment should be disclosed ________________
- All medical records related to this facility_______________ ______

If you do not want certain portions of your or your child's medical record released, please read this section carefully and initial the blanks for information you do not want released. Otherwise, your or your child's records will be released as specified above.

I do not want the following information released: Initials

- Substance abuse, if any_______________________ ______
- Psychological or psychiatric conditions, if any____________ ______
- AIDS/HIV, STD testing/diagnosis_________________ ______

This authorization expires on: ______________________________
(Date)

or when the following event
occurs:____
____

I may revoke this authorization to the extent allowed by law. If I do, I understand that Newport Pediatrics, P.C. may have already released information about me/ my child after I gave permission. I know that revoking this authorization would not prohibit any release of information by Newport Pediatrics, P.C. in reliance on my original authorization.

There are two ways to revoke this authorization. I can:

1. Sign and date a form available from Newport Pediatrics, P.C. called "Revocation of Authorization for Use and Disclosure of Health Care Information";

Or

2. Write a letter to Newport Pediatrics, P.C. If I write a letter to Newport Pediatrics, P.C., it must say that I want to revoke my authorization to disclose the patient's health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative for health care) must sign and date the letter.

Once Newport Pediatrics, P.C. gives out the information that I want released, I know that Newport Pediatrics, P.C. has no control over the information. The individual or organization that I authorize to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

Signature of Parent or Legal Guardian: ______________________ Date: ________

Relationship to Patient: ______________________________________

For Office Use Only

Signature of Employee Completing Request: ______________________________

Date Requested Information Mailed or Faxed: ____________________________