HIPAA (Health Insurance Portability & Accountability Act) AUTHORIZATION TO RELEASE INFORMATION FORM (for Adolescents 18 and above).

I, ____hereby authorize Pediatric & Adolescent Health Partners, its employees and agents, to release to ____ my personal health information maintained by Pediatric & Adolescent Health Partners (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) except the following information about me:

____

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from __________________ and will last for a period of three (3) years from date of signing or until the adolescent reaches 21 years of age.

I understand that I have a right to revoke this authorization by providing written notice to Pediatric & Adolescent Health Partners.

____ Signature of Patient

Date:______________________

Legal Representative : By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardian)

____________________________________ Signature of Legal Representative

Date:_____________________