ALASKA PEDIATRIC THERAPY

AUTHORIZATION TO OBTAIN OR RELEASE HEALTH INFORMATION PG 1

Child's name: _____ DOB: _____

1. I understand that I have the right to revoke this authorization, except to the extent that it has already been relied upon or records have already been released. I may revoke this authorization by writing to the provider to whom this was provided.

2. I understand that information disclosed under this Authorization may be re-disclosed by the recipient. The federal privacy rules may not protect my health information once the recipient re-discloses my health information.

3. I understand that I may decline to sign this authorization. I understand that covered entities may not refuse to treat me or otherwise condition benefits on signing this authorization, except that a provider may refuse to provide me with research-related treatment if I do not authorize use or disclosure of my health information for research purposes. Also, if the purpose of my treatment is solely to disclose health information to a third party, the provider may refuse my treatment if I do not agree to authorize disclosure of my health information to that third party.

4. I understand that my alcohol and/or drug treatment records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA), and Federal Regulations relating to HIPAA, 45 CFR parts 160 and 164, and that, depending on the nature of the record and treatment involved, my records may also be protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2. I understand that health information released, if covered by 42 CFR Part 2 (alcohol and drug abuse records), will continue to be protected by law from re-disclosure. However, if the information is covered only by HIPAA, it is subject to re-disclosure by the recipient and may no longer be protected. I understand that my records cannot be disclosed by covered entities beyond what is permitted under this authorization without my written consent, unless provided for by the regulations.

Alaska Pediatric Therapy is authorized to obtain or release patient information as follows:

<u>PLEASE ENTER NAME AND CONTACT NUMBER IF APPLICABLE:</u>

Pediatrician: _____ Phone:(_____)_____- _____

Case Manager/Care Coordinator: _____ Phone:(_____)_____- _____

Other agencies/therapists (OT/PT/SLP): _____ Phone:(_____)_____- _____

Hospitals/Clinics/Health Departments: _____Phone:(_____)_____- _____

School/Preschool/Child Care Program: _____ Phone:(_____)_____- _____

Counselor/psychologist: _____Phone:(_____)_____- _____

Infant Learning Program: _____ Phone:(_____)_____- _____

Other: _____ Phone:(_____)_____- _____

Other: _____ Phone:(_____)_____- _____

ALASKA PEDIATRIC THERAPY

AUTHORIZATION TO OBTAIN OR RELEASE HEALTH INFORMATION PG 2

1. I understand that I have the right to revoke this authorization, except to the extent that it has already been relied upon or records have already been released. I may revoke this authorization by writing to the provider to whom this was provided.

2. I understand that information disclosed under this Authorization may be re-disclosed by the recipient. The federal privacy rules may not protect my health information once the recipient re-discloses my health information.

3. I understand that I may decline to sign this authorization. I understand that covered entities may not refuse to treat me or otherwise condition benefits on signing this authorization, except that a provider may refuse to provide me with research-related treatment if I do not authorize use or disclosure of my health information for research purposes. Also, if the purpose of my treatment is solely to disclose health information to a third party, the provider may refuse my treatment if I do not agree to authorize disclosure of my health information to that third party.

4. I understand that my alcohol and/or drug treatment records (if any) are protected under the Health Insurance Portability Accountability Act of 1996 (HIPAA), and Federal Regulations relating to HIPAA, 45 CFR parts 160 and 164, and that, depending on the nature of the record and treatment involved, my records may also be protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2. I understand that health information released, if covered by 42 CFR Part 2 (alcohol and drug abuse records), will continue to be protected by law from re-disclosure. However, if the information is covered only by HIPAA, it is subject to re-disclosure by the recipient and may no longer be protected. I understand that my records cannot be disclosed by covered entities beyond what is permitted under this authorization without my written consent, unless provided for by the regulations.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM

_____ _____

Signature (Authorized Representative) Date

Description of Authorized Representative's authority to act for the patient:_____

A COPY OF THIS SIGNED AUTHORIZATION MUST BE PROVIDED TO THE PATIENT OR PATIENT REPRESENTATIVE