Patient Name: _____
Patient DOB: _____

BLUE FISH
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# HIPAA: Authorization of Use and Disclosure of Protected Health Information

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Blue Fish Pediatrics ("BFP")?
(Please check all that apply)

___Cell Phone ___Primary Telephone ___ Secondary Telephone

___ Regular Mail ___ Email ___ Fax Machine

Other: _____

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at BFP? (Check one)

___ Yes ___ No ___ N/A

If "No," how else may we contact you regarding this information?

_____

Please list any other restriction regarding messages or reminders about your healthcare:

_____

**Other Uses and Disclosures**: Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Practices" and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your protected health information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you provided written notice to BFP of your decision to revoke the authorization. You have the right to request restrictions on use or disclosure of your health information.

___ I would like the following restrictions regarding the use and disclosure of my health information:

_____

_____

_____

Patient Name: _____
Patient DOB: _____

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# HIPAA Authorization (page 2)

**Use and Disclosure of Information:**

___ I authorize the person(s) listed below to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at BFP.

___ I do not authorize the following information to be disclosed to any other parties except to me as the patient (please specify):

**Persons Authorized to Receive Information:**

The following health information and medical treatment BFP collects or receives about you may be disclosed to the following authorize persons to be obtained and received:

_____
Name of person / relation / organization

_____
Name of person / relation / organization

**Expiration Date of Authorization**

This authorization is effective through ___/___/_____ unless revoked or terminated by the patient or patient's personal representative.

**Right to Terminate or Revoke Authorization**

You may revoke or terminate this authorization by submitting a written revocation to BFP. You should contact the office manager to terminate this authorization.

**Potential for Re-Disclosure**

The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

_____
Name of Patient (print or type)

_____
Signature of Patient (print or type)

_____
Signature of Patient Representative (print or type)

_____
Relationship of Patient Representative to Patient (print or type)