Authorization for Use/Disclosure of Health Information

I voluntarily consent to authorize my healthcare provider:

Name: _____

Address:_____

Phone: _____ Fax: _____

to use or disclose my health information during the term of this Authorization to the recipient that I have identified below:

Acorn Pediatrics of San Antonio, 15303 Huebner #15, San Antonio, TX, 78248 Phone (210) 697-2400 Fax (210) 697-2401

Dr. Sarah Bourland, Dr. Rose Cofer, Dr. Jennifer Reynard, Dr. Michelle Storandt

Purpose: I authorize the release of my health information for the following specific purpose:

_____
(Note: "at the request of the patient" is sufficient if the patient is initiating the Authorization)

Information to be disclosed: I authorized the release of the following health information:
(check the applicable box below)

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received. This does not extend to HIV results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental records that are protected by the Lanterman-Petris-Short Act.
- Only the following records or types of health information:
  _____

Term: I understand that the Authorization will remain in effect:

- From the date of this Authorization until _____ day of _____, 20____
- Until the Provider fulfills this request
- Until the following event occurs: _____

Redisclosures: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure or my health information.

Refusal to Sign/Right to Revoke: I understand that signing this form is voluntary and that, if I do not sign, it will not affect the commencement, continuation, or quality of my treatment at Acorn Pediatrics. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Acorn Pediatrics. The revocation will be effective immediately upon my healthy care provider's receipt of my written notice of revocation, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it was received by written notice or revocation. I understand a fee may be charged in compliance with Texas State Medical Board rules.

Questions: I may contact the USC Office of Compliance for answers to my questions about privacy of my health information at 300 Figueroa Suite 105, LA, CA 90089 or via phone (213) 740-8258.

_____

Patient(s) Date(s) of Birth

_____

Parent/Guardian Name Relationship to Patient Signature Date