

**PATIENT AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

I, _____, understand

(Name of previous provider or practice) _____

(Street address of previous provider) _____

(City, State & Zip Code of previous provider) _____

is authorized by me to use or disclose my child's protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of _____ to disclose my child's protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

The patient's entire medical record

Send records to:

Catawba Pediatric Associates, P.A.
240 18th Street Circle, S.E.
Hickory, N.C. 28602

Catawba Pediatric Associates, P.A.
108 Doctors Park
Lincolnton, N.C. 28092

I fully understand and accept the terms of this authorization.

Parent's Signature

Date

Patient's Full Name

Date of Birth