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Barbara Barringer, R.N., P.N.P.
Rachel Turbyfill, P.A.
Debbie Cashion, CMPE

CATAWBA PEDIATRIC ASSOCIATES, P.A.

Unifour Medical Commons
240 18th Street Circle, SE
Hickory, North Carolina 28602
Phone: 828-322-2550 Fax: 828-322-7748

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, understand

NAME:

ADDRESS:

FAX NUMBERS:

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.

Please send the patient's entire medical record to:

Catawba Pediatric Associates, P.A.
240 18th Street Circle, S.E.
Hickory, NC 28602
Phone: 828-322-2550
Fax: 828-322-7748

I fully understand and accept the terms of this authorization.

_____ _____
Parent's Signature Date

_____ _____
Patient's Full Name Date of Birth