SHAKER PEDIATRICS, P.C.
10 CENTURY HILL DRIVE
LATHAM, N.Y. 12110-2195
Ph. (518)783-5563 Fax (518)785-5708

Patient Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize **Shaker Pediatrics** to use and/or disclose certain protected health information (PHI) about me to:

_____
(Name of entity to receive this information)

Address: _____

_____

This authorization permits **Shaker Pediatrics** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.): **All medical records**

The information will be used or disclosed for the following purpose: **Transferring to another practice.** If requested by the patient, purpose may be listed as "at the request of the individual". The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire 6 months from the date of signature.

I do not have to sign this authorization in order to receive treatment from **Shaker Pediatrics**.

In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at **Shaker Pediatrics**.

Signed By_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____ _____
Patient's Name Date of Birth Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION