4740 N Penngrove Way Meridian, ID 83646 P: 208-514-0203 F: 855-818-2019

AUTHORIZATION FORM for Thrive Pediatrics, PLLC to Use or Disclose my Health Care Information

Patient Information:

Patient Name: _____Previous Name(s):_____

Date of Birth: _____/_____/_____ Phone Number: (_____) _____-_____

Month Day Year

Records/Information Requested from: (Organization providing the information)

Name of Office/Provider: _____

Address: _____

Street City State Zip Code

Phone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

Records/Information Requested to: (Person/Organization receiving the information)

Name of Recipient/Organization: _____

Address: _____

Street City State Zip Code

Phone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

Section 4 Information Requested: (Please select one)

___ All health care information in my record

___ Health care information in my medical record relating to the following treatment/condition: _____

___ Health care information in my medical record for the date(s): _____

___ Other (i.e. x-rays, bills, etc) specify date(s): _____

Section 5 Requested format: (Please select one)

___ Fax ___ Mail ___ Pick Up

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, sexually transmitted disease (STD), acquired immune deficiency syndrome (AIDS), and/or HIV status. I under-stand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be used or disclosed.

PLEASE INITIAL THE STATEMENT THAT APPLIES (You must initial one)

_____ I **do** authorize this information to be released. _____ **I do not** authorize this information to be released

Section 6 Purpose for which the disclosure is being made: (Please select one)

____ Legal ____ Insurance ____Ongoing Care ____ Personal Use

I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re -disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that **Thrive Pediatrics, PLLC.** will not deny treatment or payment based upon whether I sign this authorization. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. I understand that I am entitled to a copy of this authorization after I sign it. **This authorization will be in effect for one year from the date signed.**

Signature of patient or legally authorized individual: _____

Date: _____

Printed name if signed on behalf of the patient: _____