INDIVIDUAL PERMISSION PROCESSING FORM
Authorization for Pediatric Associates of Western Connecticut, LLC (referred to below as "Pediatric Associates") to Use or Disclose My Health Care Information

Patient Name:	**Date of Birth:**

I. My Authorization

You may use or disclose the following health care information (check all that apply):

ı All healthcare information in my medical record.
ı Healthcare information in my medical record relating to the following treatment of condition. _____
ı Healthcare information in my medical records for the date(s): _____
ı Other (e.g., Xrays, Bills), specify date(s): _____

You may use or disclose healthcare information regarding testing, diagnosis, and treatment for (check all that apply):

ı HIV (AIDS virus) ı Psychiatric disorders/mental health
ı Sexually transmitted diseases ı Drug and/or alcohol use

You may disclose this healthcare information to:

Name (or title) and organization:

Address: City: State: Zip:

Reason(s) for this authorization (check all that apply):

ı check only if Pediatric Associates requests the authorization for marketing purposes
ı check only if Pediatric Associates will be paid or get something of value for providing health information for marketing purposes
ı at my request ı other (specify) _____

ı **This authorization ends:** (This document does not permit disclosure of health information created more than 90 days after the date it is signed).
ı in 90 days from the date signed ı on (date):_____
ı when the following event occurs: _____
(no longer than 90 days from date signed)

II. My Rights

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or,
- To receive healthcare when the purpose is to create healthcare information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Pediatric Associates based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from Pediatric Associates, or
- Write a letter to Pediatric Associates.

Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature:

Printed Name if signed on behalf of the patient:

Relationship(parent, guardian, personal rep):

Date: