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BLUE RIDGE PEDIATRICS
Professional, Personalized Care for Newborns, Children & Adolescents

NORTH PARK OFFICE PARK
457-B HWY 123 BYPASS
SENECA, SC 29678

Authorization for Use and/or Disclosure of Protected Health Information

I hereby authorize Blue Ridge Pediatrics to use or disclose my protected health information as described below:

Name of person/ facility authorized to **RELEASE** the information: _____

Phone: _____ Fax: _____

Name of person/ facility authorized to **RECEIVE** the information: __Blue Ridge Pediatrics, LLC_____

_____ Immunization record, most recent physical and growth chart
_____ Most recent ADD/ADHD visit and initial assessment

This release is for:
_____ Information only
_____ Permanent transfer of records for treatment

This authorization will expire **one year** from date of signature.

This Practice will _____ will not_____ receive payment or other remuneration from a third party in exchange for using or disclosed the protected health information.

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by the federal HIPPA regulations. I have the right to revoke this authorization in writing, and I understand that the revocation will not apply to information already released based on this authorization.

Patient name and birth date:

_____ _____
(Patient Name) (Birth Date)

_____ _____
(Patient Name) (Birth Date)

_____ _____
(Patient Name) (Birth Date)

I am the parent or legal guardian of the above named patients and I am authorized to provide this release.

_____ _____
Parent/Guardian Signature Date