



**Tri-County**  
PEDIATRICS

**Authorization for Use or Disclosure of  
Personal Information**

1. I authorize Tri-County Pediatrics, Inc. to use/disclose individual information as described below from the records of:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

2. Reason for disclosure: Routine Treatment, Payment, or at request of Consulting Specialist.

Describe each specific purpose – if disclosure is at individual's request and information to be disclosed does not include drug and alcohol treatment information, may state, "At the request of the individual".

3. I understand that:

- a. This authorization may be revoked at any time by writing to the individual/organization identified in section 1 except to the extent that information has already been disclosed. If information has already been disclosed in reliance on this authorization, revoking it will only prevent future disclosure.
- b. Tri-County Pediatrics, Inc. will not condition treatment, payment, enrollment or eligibility on the provision of this authorization.
- c. Information (except drug and alcohol information) disclosed pursuant to this authorization may be subject to redisclosure by the individual/organization identified in section A.2 below and is no longer protected by federal privacy regulations.
- d. Tri-County Pediatrics, Inc., employees, officers, and contractors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.
- e. I may refuse to sign this authorization.

**PART A-General Information**

A.1 Information to be disclosed (Identify specifically the information to be used/disclosed. If information to be used or disclosed includes mental health, drug and alcohol, or HIV-related information, please complete section on page 2 of this form that relates to that information):

\_\_\_\_\_  
\_\_\_\_\_

A.2 This information is to be disclosed to:

\_\_\_\_\_  
(Insert Name or title of the individual/organization to whom disclosure is to be made)

A.3 This authorization expires as indicated:

\_\_\_\_\_ Once acted upon  
\_\_\_\_\_ Other (specify date or event) \_\_\_\_\_

**PART B-Special Categories of Medical Information**

**B.1 Drug and Alcohol Information**

If my medical record includes drug and alcohol information, I want to send that information to the individual/organization identified in Part A of this form.

\_\_\_\_\_ Yes \_\_\_\_\_ No or Not Applicable

This information will be disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual/organization identified in Part A of this form from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**B.2 Mental Health Information**

If my medical record includes mental health information, I want to send that information to the individual/organization identified in Part A of this form.

\_\_\_\_\_ Yes \_\_\_\_\_ No or Not Applicable

**B.3 HIV/AIDS Information**

If my medical record includes HIV/Aids information, I want to send that information to the individual/organization identified in Part A of this form.

\_\_\_\_\_ Yes \_\_\_\_\_ No or Not Applicable

This information will be disclosed from records protected by Pennsylvania law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

\* \* \* \* \*

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Individual or Personal Representative  
If personal representative, state relationship to individual:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Witness Date (necessary for release of Mental Health and Drug and Alcohol information)

\_\_\_\_\_  
If individual is physically unable to sign, signature of second witness: PW-1815-8/03