AUTH TO DISCUSS HEALTH INFO

GROWING HEARTS PEDIATRIC CARDIOLOGY INC
STANDING AURTHORIZATION TO DISCUSS HEALTH INFORMATION WITH DESIGNATED PERSONS
Complete all sections of the authorization as appropriate to your request

Patient Name:_____ Birth Date:_____/____/_____
(First) (Initial) (Last)

Address: _____ Phone #:_____-_____-_____

_____
(City) (State) (Zip)

For this Authorization, “My Health Care Provider” means

_____
(Name of pediatrician, group or facility)

For this Authorization, “My Health Care Information“ means any and all information relating to my course of examination and treatment

For this authorization, "my health care information" means any and all information relating to my course of examination and treatment.
If I have initialed here, (_____), "my health information" includes substance abuse records/information.
If I have initialed here, (_____), "my health information" includes behavioral health recommendations/information.
I authorize my health care provider to discuss my health information with the person(s) or entity identified below for general information and inquiries, arranging appointments, identifying medications, discussing billing and payment, and any other related matter.

Name:_____

Relationship: _____

Phone number: _____

I understand that:

- This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not.
- If I do not sign this authorization, my health care provider will not disclose my health information as requested.
- This authorization is valid until [underline] [not to exceed 1 year in Maryland], unless I revoke/withdraw this authorization. If no date is included in this blank, this authorization will expire 1 year after the date it is signed. I may revoke/withdraw this authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original authorization to the department or office where my authorization was made or given.
- Once my health information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be redisclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, behavioral health, drug and alcohol abuse, etc.

Signature of patient only:_____Date:_____

If you are NOT the patient but are signing on behalf of the patient, complete the following:

I, _____am the [check which applies].
(Print your name)

- □ Parent with parental rights [applies only to minors] [not sufficient for substance abuse records].
- □ Informal kinship care relative [applies only to minors] [Maryland only] [not sufficient for substance abuse records].
- □ Legal guardian.
- □ Patient/plan number appointed decision maker [e.g., power of attorney] [not sufficient for substance abuse records].
- □ Default substance decision maker [e.g., surrogate, proxy] [not sufficient for behavioral health/substance abuse records].
- □ Court appointed personal representative of deceased, executor or administrator.

Representative's signature:_____
Date:_____

Address:_____
Phone:_____

You MUST attach proof of your authority to act on behalf of the patient as checked above, [other than parent].