KENILWORTH MEDICAL/HIPAA CONSENT

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure of individually identifiable health information as set forth below c/w Federal laws (including HIPAA) concerning information privacy. Failure to provide all information requested may invalidate this authorization.

Medical records disclosure information – Patient name:

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Last　　　First　　　MI　　　Date of Birth

Destination: I authorize Kenilworth Medical Associates to provide health information / medical records to:

SCHOOL ____

PICK UP　　FAX　　MAIL TO

CAMP ____

PICK UP　　FAX　　MAIL TO

ELSEWHERE ____

PICK UP　　FAX　　MAIL TO

Limits of disclosure if any (office notes, skin tests, labs, letters) **-** and purpose for which records are disclosed:

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DURATION:

This authorization is effective immediately and shall remain in effect for one year or until ______________ (date)

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights. *I may revoke this Authorization at any time. My revocation will be in writing, signed, and delivered to the school/Camp/Health care agencies/persons listed above. My revocation will be effective upon receipt, but not to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that the Requestor (School/Camp/Other) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student/patient's record.

I have a right to receive a copy of this Authorization.

APPROVAL:

______________________　　______________________　　__________

Printed Name　　Signature　　Date

______________________　　______________________

Relationship to Patient/Student　　Area Code and Telephone Number