Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:

HEALTH RECORD

Purposes of Disclosure
Information listed above will be disclosed for the following purposes:

PHYSICAL EXAM FORMS FOR SPORTS, SCHOOL, CAMPS, AND DENTIST

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

WILLIAMSTOWN PEDIATRIC PRACTICE
Name of person/organization

Name of person/organization

Name of person/organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

Name of person/organization

Name of person/organization

Name of person/organization

Expiration Date of Authorization
This authorization is effective through / / unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to **WILLIAMSTOWN PEDIATRICS**. You should contact the **THE PRIVACY OFFICER** to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once **WILLIAMSTOWN PEDIATRICS** discloses it to another party.

Rights of the Individual
- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization.

Effect of Refusing Authorization
If you refuse to sign this authorization, **WILLIAMSTOWN PEDIATRICS** will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

Treatment conditioned on authorization

Treatment conditioned on authorization

Signature

Name of Patient (Print or Type)

Signature of Patient Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

WILLIAMSTOWN PEDIATRICS reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for
WILLIAMSTOWN PEDIATRICS.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient