

# Patient Authorization Form for Medical Services

FOR USE AND DISCLOSURE OF PRIVATE HEALTHCARE INFORMATION (PHI)

## Patient (and/or Responsible Party) confirming this authorization to release PHI

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Home Work Other  
Address: \_\_\_\_\_ Pat. ID: \_\_\_\_\_  
\_\_\_\_\_  
Email Address: \_\_\_\_\_  
Responsible Party Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at this clinic. I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. **Initial** \_\_\_\_\_

## AUTHORIZED USES AND DISCLOSURES

I give authorization to use or disclose my protected health information (PHI) for reasons including, but not limited to, those described below:

The PHI will be used/disclosed for:

- Treatment provided me at this care provider, Mendakota Pediatrics, Ltd.
- Billing purposes between my care provider and all of my insurance carriers
- School enrollments and Immunization records

**Initial** \_\_\_\_\_

## INDIVIDUAL PATIENT'S SIGNATURE

I have read the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the PHI described in this form .

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this authorization is signed by a personal representative for the individual patient:

**Responsible Party's Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to the Patient:** \_\_\_\_\_

## Patient Acknowledgement Form Receipt of Privacy Practices Statement

I acknowledge that I have been given the Notice of Privacy Practices for Mendakota Pediatrics, L TO, and have had a chance to review it.

\_\_\_\_\_  
Patient/Responsible Party's Name (Please Print)

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date