Pediatric Associates of Durango (PAOD)
Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Contact/Phone Number

Responsible Party Legally Authorized to Make this Request if Patient is Under 18 years of age (PLEASE PRINT):

Name: _____ Relationship to Patient: _____

I hereby authorize disclosure/release of the Protected Health Information specified in this request to the organization, agency or individual named below:

Release ☐TO ☐FROM:

Pediatric Associates of Durango
1199 Main Ave., Suite 205
Durango, CO 81301
Phone/FAX: 970-259-7337/7366

Release ☐FROM ☐TO:

Organization/Agency/Individual: _____
Address: _____
City, State, Zip: _____
Phone/FAX: _____

For the purpose of: □ Continuing Care/Treatment □ Legal □ Personal Use □ Insurance
□ Other (please describe) _____

Specific records to be released*: ☐ Entire PAOD Medical Record ☐ Entire Record

□ Other (please specify) _____
Dates of Service (between): _____ and _____

Please Note: The information to be released may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care, sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); drug and/or alcohol abuse, or sexually transmitted diseases.

To **EXCLUDE** any of this information, please initial next to each as necessary:
___ Drug/alcohol abuse/treatment & diagnosis ___Reproductive health care ___ Sexually transmitted disease
___Mental health/psychiatric treatment ___HIV/AIDS diagnosis/treatment/testing

***Patient signature required below to release these specific records:**

- Patient age **13 or older:** Reproductive health including pregnancy and sexually transmitted disease, HIV/AIDS, or drug/alcohol treatment information.
- Patient age **15 or older:** Behavioral health or psychiatric care information.

I understand the following: This authorization will automatically **expire** one year from the date signed below or the date the minor child becomes an adult under state law, unless I request an expiration date sooner than one year. I may choose to **revoke** this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying Pediatric Associates of Durango in writing. Information disclosed pursuant to the authorization may be subject to **re-disclosure** by the recipient and is no longer protected by the HIPAA Privacy Rule. I have a right to a **copy** of this authorization. PAOD will still provide treatment and seek payment for services provided, whether or not I sign this authorization. PAOD may charge for copies of medical records.

_____ _____ _____

Signature of Responsible Party **Date** ***Signature of Patient** (when required)