PEDIATRIC ASSOCIATES OF DURANGO

Pakhi Chaudhuri, MD, FAAP
Jessica Rensner, MSN, RN, CPNP

1199 Main Ave, Suite 205 Durango, CO 81301
970-259-PEDS (7337) • www.paofdurango.com

**Patients Name:** _____ **Patients DOB:**_____
**Contact Number:**_____

## Authorization to Disclose Protected Health Information

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

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: _____ Phone/FAX: _____

Address: _____ City, State, Zip: _____

**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.

| Responsible Party Full Name | Responsible Party Signature | Date |
|---|---|---|

(when required)

| Client Signature | Date |
|---|---|