SKYLANDS PEDIATRICS
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____
Last First Middle
Home Address: _____
_____
Home Telephone: _____ Cell Phone: _____ Date of Birth _____
SPECIFY INFORMATION TO BE DISCLOSED: _____
_____
_____
_____
_____
Note: If your health information contains any genetic, HIV/AIDS related (i.e. information regarding any HIV related test, infection, illness including AIDS), venereal disease and/or tuberculosis information, you must specifically mention "genetic information", "HIV/AIDS related information", venereal disease information and/or "tuberculosis information" if you want Skylands Pediatrics to disclose such information to any person other that you or your personal representative.
RECIPIENT: Name or person or class of persons to whom Skylands Pediatrics may disclose my health information:
_____
_____
Relationship: _____
TERM: This authorization will remain in effect:
[ ] From the date of this authorization until the _____ day of _____, 200___.
[ ] Until the following event occurs: _____.
[ ] Other: _____.

By my signature below, I hereby authorize Skylands Pediatrics to use or disclose to the recipient my health information for the term of the Authorization for the following specific purpose(s): ("At the request of the patient" is sufficient if the patient is initiating this Authorization) _____
_____
_____

I understand that once Skylands Pediatrics discloses my health information to the recipient, Skylands Pediatrics cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that once Skylands Pediatrics will, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Skylands Pediatrics' treatment of me; except, however, if my treatment at Skylands Pediatrics is for the sole purpose of creating health information for disclosure to the recipient identified in the Authorization, in which case Skylands Pediatrics may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Skylands Pediatrics' Privacy Office at the address listed below. The revocation will be effective immediately upon Skylands Pediatrics in reliance on this authorization before it received my written notice of revocation.

I may contact Skylands Pediatrics Privacy Officer by mail at 328A Sparta Avenue, Sparta, New Jersey 07871.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Skylands Pediatrics to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient Date