Woodland Park Pediatrics, PC
214 Lackawanna Ave
Woodland Park, NJ 07424
Phone: 973-582-0644, Fax: 973-582-0605
Patient Authorization to Obtain/ Release
Protected Health Information

By signing this authorization, I authorize Woodland Park Pediatrics PC to obtain, use and/or disclose certain protected health information (PHI) about me as described below:

_____
Name of the Practice with Phone / Fax

The following individually identifiable health information (Check all that apply):
_____ Immunizations _____ Referrals/Consultations _____ Complete Chart

This request may include disclosure of information relating to ALCOHOL/DRUG TREATMENT, MENTAL HEALTH INFORMATION, and CONFIDENTIAL HIV-RELATED INFORMATION only if Patient's/Legal Guardian's initials are included next to the desired information below.

____ Alcohol/Drug Treatment ____ Mental Health Information _____ HIV-Related Information

This protected health information is being used or disclosed for the following purpose (list specific purposes)

_____Transfer Medical Record _____Other_____

This authorization shall be in force and effect until the following date/event, at which time this authorization to use or disclose the protected health information expires.

_____This authorization is valid for the entire academic school year 20___ - 20___
_____This authorization shall expire on _____/_____/_____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Woodland Park Pediatrics PC has acted in reliance upon this authorization. My written revocation must be submitted to Woodland Park Pediatrics PC HIPAA Manager at 214 Lackawanna Ave, Woodland Park, NJ 07424.

Signed by: _____ _____
Signature of Patient or Parent/Legal Guardian — Print Name of Patient or Parent/Legal Guardian

_____ _____
Patient(s) Name(s) and DOB — Relationship to Patient

_____
Patients(s) Names(s) and DOB

_____
Patients(s) Names(s) and DOB

Patient (s) Address: Phone Number _____
Street _____

City, State Zip_____