Pediatric Partners of Virginia
HIPAA Form D
Patient Authorization for Practice to Release PHI to Third Parties

By signing this authorization, I authorize Pediatric Partners of Virginia to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below for the following reasons only as per the HIPAA Privacy, Security, Enforcement and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Act (HITECH) and the Genetic Information Nondiscrimination Act (GINA) published January 25, 2013:

( ) Marketing activities

( ) Disclosure of psychotherapy notes

This authorization permits Pediatric Partners of Virginia to use or disclose to (Person or Entity to Receive the information) _____ the following individually identifiable health Information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

This authorization will 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 understand that I have the right to revoke or modify this authorization in writing except to the extent that Pediatric Partners of Virginia has acted in reliance upon this authorization. My written revocation or modification must be submitted to:

Pediatric Partners of Virginia
Corporate Administrator
3458 Lauderdale Drive
Henrico, VA 23233

_____
Patients Name

_____ _____ _____
Signature of Parent/Guardian Printed Name Date