SEE Alternatives Pediatrics (a division of SEE Alternatives, LLC)
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The Covered Entity may use or disclose your protected health information ONLY for purposes of treatment, payment, health care operations or other reasons permitted by law (please review the Entity's Notice of Privacy Practices for more information). You must authorize any other use or disclosure of your protected health information. You have the right to refuse this authorization.

Part 1. INDIVIDUAL'S INFORMATION		
Individual's Name:		Date of Birth:
Home Street Address:		Phone Number:
City:	State:	Zip Code:

Part 2. INFORMATION ABOUT THE USE or DISCLOSURE

I, the undersigned individual, hereby voluntarily authorize the following Entity and its business associates to disclose information from my health record.

The information is to be disclosed by:	**And is to be provided to:**	
Name of Facility:	Name of Person/Organization/Facility: **SEE Alternatives Pediatrics**	
Address:	Address: **3227 Walter Dr. Ste C1, Johns Island SC 29455**	
Phone:	Phone: **843.920.0046**	Fax: **843.920.0001**

Purpose for Disclosure:

☐Changing Healthcare Provider ☐Consultation ☐Referral to Specialist ☐Legal ☐Personal Use

☐Other *(specify)*_____

Information to be disclosed from my health record:

☐Entire record ☐Diagnostic Reports [labs (including drug tests), x-ray, MRI, etc.] ☐Progress notes

☐Only information related to (specify)_____

☐Only the period of events from _____ to _____.

☐Other *(specify)* _____

I understand and agree the following sensitive information will be disclosed if I place my **initials** in the applicable space next to the type of information.

_____ **Drug/alcohol diagnosis, treatment, or referral information** _____ **Genetic testing information**

_____ Mental health information _____ HIV/AIDS information

I understand that if this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration* event is specified. **Expiration Date/Event of Authorization**: _____

Part 3. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

Part 4. SIGNATURE of INDIVIDUAL or REPRESENTATIVE

I hereby authorize the Entity and its business associates to use or disclose my protected health information as described in Part 2.

_____ Signature of individual or legal representative	_____ Date
_____ Printed name of individual's legal representative, if applicable	_____ Representative's relationship to individual