

**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: 833-971-1930
Purpose for Disclosure:		
<input type="checkbox"/> Changing Healthcare Provider <input type="checkbox"/> Consultation <input type="checkbox"/> Referral to Specialist <input type="checkbox"/> Legal <input type="checkbox"/> Personal Use <input type="checkbox"/> Other (specify) _____		
Information to be disclosed from my health record:		
<input type="checkbox"/> Entire record <input type="checkbox"/> Diagnostic Reports [labs (including drug tests), x-ray, MRI, etc.] <input type="checkbox"/> Progress notes <input type="checkbox"/> Only information related to (specify) _____ <input type="checkbox"/> Only the period of events from _____ to _____. <input type="checkbox"/> 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I understand that if this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or <i>expiration</i> 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:
<ul style="list-style-type: none"> 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