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: ____________________ Phone Number: ______________________________

Street Address: ______________________________

City: ______________________________ State: __________ Zip: ______________

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:
SEE Alternatives Pediatrics
3227 Walter Dr. Ste C1
Johns Island SC 29455
Phone: 843-920-0046
Fax: 833-971-1930

And is to be provided to:

Name of Person/Organization/Facility: ______________________________

Street Address: ______________________________

City: ______________________________ State: ________ Zip: ____________

Phone: ____________________ **Fax:** ____________________

Purpose for Disclosure: Transition to provider due to closure of SEE Alternatives Pediatrics

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/Psychoeducational testing

________ 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I understand that if this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is specified.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