Bard and Didriksen Pediatrics

Patient Authorization for Use and Disclosure Of Protected Health Information

With my authorization, Bard and Didriksen Pediatrics, P.C. may use and disclose protected health information (PHI) about my child to carry out treatment, payment and health operations (TPO). Please refer to Bard and Didriksen's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this Authorization. Please initial each area where permission is granted.

( ) With my authorization, Bard and Didriksen Pediatrics may call my home or other designated location and leave a message on voice mail or in person regarding upcoming appointments, including the balance on my account.

( ) With my authorization, Bard and Didriksen Pediatrics may mail, fax or email (encrypted) to my home or other designated location my child's:
_____ Vaccine records ____school physical forms ____ notes stating non-contagious
______ Authorization to dispense medicine form
( ) ______________________________ School ________________________ Daycare
( ) Women, Infants and Children's program (WIC)
( ) Authorized Email address: ____

( ) With my authorization, Bard and Didriksen Pediatrics may fax, e prescribe or call my child's prescription to my designated pharmacy.
Pharmacy Name: ____

I have the right to request that Bard and Didriksen Pediatrics restrict how it uses or discloses my child's PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my authorization in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I authorize the following persons, **other than legal guardians**, to have access to this PHI when accompanying my child when receiving medical care or during telephone conversations with Bard and Didriksen Pediatrics personnel. This information may include discussion about the balance on my account.

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Names | Relationship

______________________________ | ______________________________

Signature of patient or legal guardian | Printed Name of Patient

______________________________ | ______________________________

Printed name | Date