# Authorization for Authorized Representative Access to Adult Patient's Protected Health Information

I authorize and request MD Pediatric Associates to grant my designated authorized representative identified here ( "Authorized Representative") access to portions of my electronic protected health information, including clinical and billing information, maintained through MD Pediatrics.

Authorized Representative's Name: _____ DOB: _____

Email: _____ ID# (drivers' license, etc): _____

Street Address: _____

City, State, Zip: _____

Shared data may include: Electronic Protected Health Information (ePHI) including but not limited to: Secured Messaging, Appointments, Test Results, Medications, Allergies, Immunizations, Preventive Care, Medical History, Hospital Admissions, Patient Portal, Billing & Insurance, Letters, Diagnoses, Current Health Issues

I Understand That Information may include mental health, substance abuse or STD diagnosis, treatment or medications.

I may revoke this authorization at any time by submitting a signed letter indicating my wishes to MD Pediatric Associates. Such revocation shall not affect disclosures made prior to the revocation.

Information disclosed pursuant to the authorization may be subject to redisclosure by my Authorized Representative and may no longer be protected by the HIPAA Privacy Rule.

This authorization is voluntary. If I do not sign or if I revoke this authorization, MD Pediatric Associates will still provide treatment to me and will seek payment for services provided.

This authorization is valid unless and until I revoke the Authorized Representative's ePHI access.

Printed Name: _____ DOB: _____

Signature _____

Patient's Personal Email for portal invitation: _____

Patient's Phone number: _____

Today's Date_____

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