

Patient number (to be filled in by practice): # _____

Authorization for Disclosure of Protected Health Information

Pennsylvania Chapter of the American Academy of Pediatrics
EPIC-IC- Educating Practices in Community-Integrated Care/Medical Home Program

Notice of Privacy Practices

Patient Name _____ **Date of Birth** _____

Parent/Guardian Name _____

Phone _____ **Email** _____

Address _____
Street Address City State Zip Code

I give my authorization/permission for my child's primary care physician, _____

To provide the **PA Chapter of the AAP Medical Home Program** information regarding my child's condition and any activities related to care coordination performed by the practice. This information will be used to collect data for state and national studies about children with chronic conditions. I also give my permission for a representative of this program to contact me if necessary to participate in a survey including accessibility of services for my child and other areas of interest. From first treatment date through 6-30-12 which constitutes the end of the grant period.

I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (HIPAA) and the recipient of this health information may include it in group data reporting and potentially re-disclose it. However, under the Federal Substance Abuse and Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

This consent is subject to revocation at any time, except to the extent that the organization which is to make the disclosure has already taken action in reliance on it. This information is being disclosed from records protected by federal regulation and Pennsylvania state law. Further disclosure of this information is prohibited except with the written consent of the person or guardian to whom it pertains, or as otherwise permitted or authorized by the applicable state and federal laws and regulations. A general authorization is not sufficient for this purpose.

Date _____ **Relationship to Patient** _____

Signature _____

The Pennsylvania Medical Home Initiative may ask you to complete a survey about the challenges that you, as a caregiver, face in obtaining the best care for your child. Information from this survey will be used to develop policies, guidelines, and recommendations to improve health care for children in Pennsylvania. Any contact information you provide will only be used for the purposes of the survey and will never be disclosed to third parties.

If surveyed, I would prefer to be contacted by:

Mail Email Phone _____
Best time to call