

PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Neonatal Care, INC or Dr. Rachel Zylberberg, M.D. to use and disclose the following Protected Health Information including but not limited to pertinent medical information , vaccination records and examination records.

This Protected Health Information may be utilized for enrollment in activities, daycare programs or educational institutions.

I understand and acknowledge that;

- 1) The office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above
- 2) This authorization is voluntary and I may refuse to agree to its items without affecting any of my rights to receive health care at the practice
- 3) This authorization may be revoked at any time by notifying the practice in writing at the above address to the attention of the Privacy Officer
- 4) The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation
- 5) The information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and thus this information will no longer be protected by federal privacy regulations
- 6) My health care and payment for my healthcare will not be affected if I do not sign this form
- 7) I may see and copy information described in this form, if I ask for it, and that I will get a copy of this form after I sign it
- 8) This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, and I fully understand this authorization form, and have received an executed copy
- 9) This authorization is valid as of the date signed below and shall remain valid for a period of one year

Name of Individual Printed _____

Signature of Individual _____

Date _____