PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize THE PERICO GROUP to disclose certain protected health information about me to:

_____

Name and Address

THE PERICO GROUP is hereby authorized to disclose the following protected health information (specifically describe the information to be disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

□ All Medical Records
□ x-Rays/CT scans
□ Specific Information: _____

I understand that this request does not apply to: (1) certain health information that is not held in THE PERICO GROUP'S medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA. The information may be disclosed for the following purpose: _____.

This authorization will expire 90 days after the date of its execution or on _____ (enter specific date), unless expressly revoked by me at an earlier time. I understand that THE PERICO GROUP may not condition my treatment on whether I sign this authorization. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA. I understand that I may revoke this authorization at any time by delivering a revocation in writing to THE PERICO GROUP at 90 Humphrey Street, Swampscott MA 01907, and if I revoke this authorization, it will have no effect on actions already taken by THE PERICO GROUP in reliance on this authorization. I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative.

Signature of Patient/Legal Guardian: _____ Date: _____

Printed Name of Patient of Legal Guardian: _____

Patient Name: _____ Social Security Number: _____

Address: _____ Date of Birth:_____

Phone: _____

Witness: _____ Date: _____

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION