Black Hills Pediatrics, L.L.P.
Authorization For Use And Disclosure
Of Protected Health Information To Personal Representatives
Patient 18 Years of Age or Older

According to HIPAA regulations, Black Hills Pediatrics, L.L.P., may not use or disclose your protected health information (PHI) without your authorization. Your signature on this form indicates that you are giving permission for the use and disclosure of your protected health information to your personal representative(s) as listed below. You may revoke this authorization at any time by signing and dating the revocation on this form.

I, _____, (print name) hereby authorize and request the use and disclosure of all my protected health information to my personal representative(s). I authorize Black Hills Pediatrics, L.L.P., to make those disclosures. I authorize and request the following person(s) to receive those disclosures of my protected health information and elect not to provide a statement of purpose for the use of the disclosures.

_____ _____
Please Print Name Relationship

_____ _____
Please Print Name Relationship

I understand that the information disclosed pursuant to this authorization may possibly be re-disclosed by a personal representative to additional parties and will no longer be protected health information.

I understand that this authorization will automatically expire one (1) year from the date of signature, but that I may revoke this authorization at any time in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____
Signature Date

_____
Please Print Name

Complete this section if you wish to revoke this authorization:

I revoke this authorization effective _____ (date).

_____ _____
Signature Date

_____
Please Print Name

Revised 4/1/14