

**COMFORT CARE PEDIATRICS, INC.**  
**4546 South 815 West, Suite 204**  
**Taylorsville, UT 84123**  
**(801) 595-8844**

**HIPAA AUTHORIZATION ACKNOWLEDGMENT**

I hereby authorize the use and disclosure of my child's protected health information as described in the HIPAA Notice of Privacy Practices and understand and acknowledge the following:

- I am not required to sign this authorization and may, in fact, refuse to sign this authorization.
- Comfort Care Pediatrics, Inc. will not condition my child's treatment or payment for my child's treatment on obtaining this authorization from me, unless permitted by law.
- If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
- I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
- I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to the Privacy Officer at Comfort Care Pediatrics, Inc. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.
- If I have any questions about this authorization, I may contact the Privacy Officer at (801) 595-8844, who will provide me with more information about this authorization, or about Comfort Care Pediatrics' privacy practices.

I acknowledge that I have been provided with the opportunity to read the HIPAA Notice of Privacy Practices.

I understand that I may request my own copy of the HIPAA Privacy Practices.

I understand that Comfort Care Pediatrics, Inc. has a separate medical release form that will be used for specific medical record release requests. The "Authorization for Comfort Care Pediatrics, Inc. To Release Medical Records" form details the following for each request:

- Specific information to which the authorization applies.
- Person or organizations that are authorized to receive my child's protected health information.
- The specific purpose for such authorized use or disclosure of my child's protected health information.

I understand that the specific authorization for disclosure of my child's protected health information will expire when the records requested have been sent, faxed, or picked up.

I understand that a medical records copying fee may be assessed and that the use or disclosure of requested information may result in direct or indirect compensation from a third party (for example, an insurance company may pay the medical records copying fee). However, I also understand that many insurance companies do not pay a medical records copying fee and, under these circumstances, that the charge for this service would be my responsibility.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Legal Guardian

Printed: \_\_\_\_\_  
Name of Parent or Legal Guardian

Rev 03-03 per HIPAA Regulations