

EXHIBIT 3
AUTHORIZATION FOR RELEASE OF INFORMATION
To Schools & Daycares

Must be completed for all authorizations

I hereby authorize the use or disclosure of my health information as described below. By signing this authorization, I authorize Pediatric & Adolescent Associates to use and/or disclose certain protected health information (PHI) about me to the entity listed below.

Patient Name: _____ D.O.B.: __/__/__ Patient Name: _____ D.O.B.: __/__/__

Patient Name: _____ D.O.B.: __/__/__ Patient Name: _____ D.O.B.: __/__/__

Organization/Persons receiving the information: (Please list name and address.)

School Name: _____ Daycare Name: _____ Other: _____

This authorization permits Pediatric & Adolescent Associates to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed):

Immunization Certificates, school excuses, school forms, medication instructions; _____

For the following purpose:

As requested by school, daycare, or parent via mail, phone or fax; _____

I do not have to sign this authorization in order to receive treatment from Pediatric & Adolescent Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 3050 Harrodsburg Road, Lexington, KY 40503.

I understand that this authorization is valid for 1 year from date signed, unless revoked in writing.

Signature of Patient or Legal Guardian

Print name

Date

Relationship to the Patient