



# Pediatric Partners, LLC

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## Authorization for Disclosure of Health Information

I hereby authorize \_\_\_\_\_  
(Name of Provider) (Fax Number)

\_\_\_\_\_  
(Practice Name & Address)

to disclose the following information from the health records of:

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

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Information to be disclosed: **PARENT OR LEGAL REPRESENTATIVE SHOULD INITIAL RATHER THAN CHECK ALL THAT APPLY!!**

- |  |   |
|--|---|
| <input type="checkbox"/> complete health record(s) | <input type="checkbox"/> discharge summaries          |
| <input type="checkbox"/> history & physical exams  | <input type="checkbox"/> progress notes               |
| <input type="checkbox"/> consultation reports      | <input type="checkbox"/> laboratory tests             |
| <input type="checkbox"/> x-ray reports             | <input type="checkbox"/> photographs, digital images, |
| <input type="checkbox"/> immunizations records     | <input type="checkbox"/> video                        |
| <input type="checkbox"/> other _____               |   |

I understand that this could include information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care, and treatment for alcohol and/or drug abuse.

This information is to be disclosed to \_\_\_\_\_ for the purpose of \_\_\_\_\_.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(parent or legal representative)

Relationship to patient: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_