Pediatric Partners, LLC

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Board Certified in Pediatrics

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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!!***

___complete health record(s)
___history & physical exams
___consultation reports
___x-ray reports
___immunizations records
___other_____
___discharge summaries
___progress notes
___laboratory tests
___photographs, digital images,
___video

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:_____

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