NORTHAMPTON AREA PEDIATRICS, LLP

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Pediatric and Adolescent Medicine

Authorization to Release Medical Information to Family Members

Patient Name: _____ **Date of Birth:** _____

☐ I, _____, give permission for Northampton Area Pediatrics to disclose and release information to my family member(s) listed below as necessary for coordination of medical care and services.
I am granting permission for disclosure because I would like the below mentioned persons to be involved in my healthcare.

Name:	Relationship:	Phone number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

The above named persons may request/receive the following information (Check either A or B):

☐ A. **My complete health record** (including, but not limited to: diagnoses, lab tests, prognosis, treatment, refill requests, and billing)
☐ Specific information I do **NOT** want shared (ie: birth control, lab results, a specific diagnosis):
_____

OR

☐B. I **ONLY allow** communication related to:
☐ Appointments
☐ Medical care, an issue or concern
☐ Lab results
☐ Vaccines
☐ Request and pick up prescriptions and forms

Information may be disclosed as:
☐ Verbal only
☐ Verbal or printed copies upon request

☐ I do **NOT** give permission for Northampton Area Pediatrics to share, release, or disclose any of my medical information to any of my family members. I understand this means that NAP will only be able to communicate with me directly for all of my health needs, including refill requests, appointments, and letters/forms for work or school. **Patient initials: _____**

This authorization is effective for 1 year and will be renewed at each annual well visit.
NOTE: You may revoke this authorization at any time by notifying Northampton Area Pediatrics in writing.

Patient Signature: _____ Date Signed: _____
18 years or older