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***Pediatric and Adolescent Medicine***

# Authorization to Release Health Information

**Select one:** ☐ **Transfer OUT** ☐ **Copy for Self**
☐ **Transfer IN** ☐ **Coordination of Care** (e.g. family/school)

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

I request and authorize ☐ Northampton Area Pediatrics ☐ Other _____
to release health information to:

Name/Facility: _____

Address: _____

Phone Number: _____ Fax: _____

I authorize this information to be faxed (when applicable) ☐ YES ☐ NO Patient Initials _____

This request for authorization applies to:

□ Medical notes for visits at Northampton Area Pediatrics dated: _____

□ Test Results: _____

□ Related to Diagnosis: _____

□ Other: _____

*Release of sensitive information regarding HIV/AIDS, Genetic Information, Treatment of Alcohol and/orDrug Abuse, and Sexually Transmitted Diseases, requires a separate release form.*

Without my express revocation, I understand that this authorization will expire 1 year from the date signed unless indicated below:

Under the following condition(s):_____

Upon satisfaction of the need for disclosure on _____
(enter a future date other than date signed by patient not to exceed 1 year)

I may revoke this authorization in writing, but any previously disclosed information would not be subject to such revocation. I may inspect or copy the information to be used or disclosed and may refuse to sign the authorization. My refusal to sign will not affect my ability to obtain treatment.

Guardian/Parent Signature: _____ Date Signed: _____

Relationship to Patient: _____

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