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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 **Name/Facility A** to release health information to **Name/Facility B**:

From:

Name/Facility A: ____

Address: ____

Phone Number: ______________________ Fax: ______________________

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

To:

Name/Facility B: ____

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 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