AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

1. I hereby authorize the use or disclosure of my (child/ren's) health information as described below. I understand the information disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations:

Patient Name(s) _____ Date(s) of Birth _____

_____ _____

_____ _____

_____ _____

Address _____ Telephone _____

_____

Covering the following dates:
From (date) _____ To (date) _____

2. Information to be disclosed:

- ❑ **Complete Health Record(s)**

OR only the following:

- ❑ Visit Notes
- ❑ Physical/Well Visit Examinations
- ❑ Laboratory Tests
- ❑ Billing/Financial

3. _____ (Initials) I specifically consent to the release of any information related to testing and treatment for HIV, AIDS, mental health/psychiatric care, or alcohol and/or drug abuse if such is contained in the medical records. This provision MUST be initialed by person giving consent or this information will NOT be released.

4. This information is to be disclosed to:
Pediatric Clinic, a Member of Summit Medical Group
_____
_____
Fax: _____

Information disclosed by: (name and address)
_____
_____
_____
_____

5. This authorization will expire on _____, not to exceed one year. I understand this authorization maybe revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. If I fail to specify a date or otherwise revoke this authorization, this authorization will expire one year from the date signed below.

6. I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: **1.** Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. **2.** Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

Signed: _____ _____
Patient Date

_____ _____
(OR) Parent/Guardian Date

_____ _____
Witness Date