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# Authorization to Release Information

Patients Name:_____ Date of Birth:_____
Address:_____
Phone:_____SS#:_____

I authorize (please print name of previous Doctor or Facility_____to disclose above named individual's health information. (only checked boxes below) to Professional Pediatrics. Please give phone and fax numbers if available.

Phone:_____ Fax:_____

Problem List ( )
Medication List ( )
List Of Allergies ( )
Immunization Record ( )
Most recent History & Physical ( )
Most recent Discharge Summary ( )
Laboratory Results ( ) Date: _____
X-Ray and Imaging Reports ( ) Date:_____
Consultation Reports ( )From:_____
Designated Record Set ( )

I understand that the information in my health record may include information relating to sexually transmitted diseases. AIDS, and HIV. Included may also be information about behavioral or mental health services, and treatment for drug and alcohol abuse.

I understand that I have the right to revoke authorization at any time. Understanding that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The authorization will expire in six months unless otherwise dated here. ___/____/_____.

I understand that authorizing disclosure of health information is voluntary. Refusing to sign this authorization is your choice. I need not sign this form in order to ensure treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ Date:_____
Signature of Parent, Guardian or Self

_____ Date:_____
Witness