PEDIATRICS
5280, PC

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Patients 18 Years or Older Release of Health Information

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

Home Number: _____ **Cell Number: _____**

I authorize the following people to receive information:

Name	Relationship	Phone Number
	/	/
Name	Relationship	Phone Number
	/	/

I authorize the following health information to be disclosed:

- ☐ Any and all information about the patient's treatment;
- ☐ Laboratory results;
- ☐ X-Ray reports;
- ☐ Medical instructions or advice;
- ☐ Prescription drug information;
- ☐ Drug abuse;
- ☐ Alcohol abuse;
- ☐ Sexual activity or HIV/AIDS or STDs;
- ☐ Psychological or psychiatric conditions, including psychotherapy notes;
- ☐ Other (specify): _____

* I understand that this may include detailed personal medical information including medical services to be provided, notification that items such as refills are ready for pick-up, as well as any information listed above.

MY RIGHTS: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

To take part in a research study.
To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

1. Fill out a revocation form. The form is available from the office.
2. Write a letter to the office.

Once the office discloses health information, the person or organization that received it may re-disclose it. Privacy laws may no longer protect it.

I have had the opportunity to ask questions and receive answers regarding my rights.

This release expires 6 months from signature date.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____ _____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)