PEDIATRIC ASSOCIATES, LLP

Release of Information Authorization Form

I understand that my records may contain information regarding the diagnosis or treatment of sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric disease. I understand that in accordance with Federal and State laws, this release does not include permission to release information specifically related to HIV (AIDS) and if such information is to be requester, additional specific release forms are required. I authorize the disclosure of health information as described below.

PATIENT NAME ______________________________________ **BIRTHDATE** ______________

Who is releasing / exchanging information:

____

Name of Person/Organization

____

Address

Who would you like to receive / exchange information:

____

Name of Person/Organization

____

Address

Reason for Disclosure: ____

Description of information that may be disclosed: _____________________________

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Expiration Date of Authorization

This authorization expires one year from the date signed (or _____/_____/_____) unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

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Signature of Patient (if 18 years old or older) Date

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Relationship of Patient Representative to Patient