Pediatric Associates of Brunswick

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Authorization For Release of Information

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

Address: _____

Telephone Number: _____

I authorize the release of medical information as indicated below:

FROM:	**TO:**
Name: _____	**Name:** _____
Address:_____	**Address:** _____
_____	_____
Phone: _____	**Phone:** _____

☐ I would like to pick up my records ☐ I would like records mailed to address listed above

What to Release: Please choose the records you would like released-

☐ Immunization Record
☐ All medical records
☐ Laboratory Reports
☐ Other- Specify_____

The records listed below have special protection by laws. I authorize the release of information pertaining to:

The diagnosis or treatment of AIDS, including HIV tests	☐ Yes	☐ No/NA
The diagnosis or treatment of drug and/or alcohol abuse	☐ Yes	☐ No/NA
The treatment and/or consultation for mental health or psychiatric disorders	☐ Yes	☐ No/NA

Purpose of the release: Please indicate the reason for this release-

☐ For another doctor:
- ☐ Moving
- ☐ Switching doctors
- ☐ Other: _____

☐ Use in a lawsuit
☐ Follow-up related to an injury
☐ Personal use
☐ Other- Specify_____

Expiration date: This authorization will expire in sixty days unless otherwise indicated below:

☐ Please change the expiration date to last for _____ days

I understand this authorization can be revoked at any time according to Pediatric Associates of Brunswick's privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of the release if possible. Treatment, payment, enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Pediatric Associates of Brunswick and may potentially be re-disclosed by the party who received these records. Pediatric Associates of Brunswick, its employees and officers, and attending physicians are released for legal responsibility or liability for the release of the above information to the extent indicated and authorized.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

_____ _____
Signature of the parent/legal guardian Date