AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION
PARTNERS IN PEDIATRICS, PC
2525 E. BROADWAY SUITE 201
HELENA, MT 59601
PHONE (406)447-2885
FAX (406)447-2883
*** * * * * * * * * ***

_____ _____ _____ _____
Patient Last Name First Name MI Date of Birth

_____
Street/P.O. Box Address

_____ _____ _____ _____
City State Zip Daytime Phone Number

I hereby authorize **Partners in Pediatrics** to:

Request information from:

NAME:_____ ADDRESS:_____

PHONE:_____ FAX:_____

&

Disclose information to:

NAME:_____ADDRESS: _____

PHONE:_____ FAX:_____

INFORMATION REQUESTED/TO BE DISCLOSED (Circle all that apply):

Immunization Record	Consultations	
Office Notes	Entire Patient Chart	Send as PDF on CD
Lab/Special Reports	Other (Please specify):	

Partners in Pediatrics may not condition treatment or payment on whether an individual signs this authorization.

*The patient chart includes all health care information, whether oral or recorded in any form or medium that identifies the patient or can readily be associated with the patient and relates to the patient's care. This includes all health care information in the possession of **Partners in Pediatrics**, whether generated by the Clinic or any other source, as well as health care information associated with drug/alcohol abuse, mental or psychiatric care, abortion, and HIV status or diagnosis of AIDS or other sexually transmitted diseases, including hepatitis.*

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the office manager of Partners in Pediatrics, up to the extent that the disclosure has not already been made or such disclosure is required to effectuate payment for health care. I also understand that any protected health information may be redisclosed by the recipient and no longer be protected under federal law. This authorization will expire in six months. I confirm that I am a legal guardian of the patient and the patient is not in custody of Child Protective Services.

_____ _____
Patient Signature (if over 18) Date

OR

_____ _____ _____
Parent/Legal Representative/Guardian Date Relationship to Patient