Flanders Pediatrics, LLC

Maria A.Lopez, MD, FAAP
Amy Blodgett, MD, FAAP
Zachary Kahn, DO, FAAP
Elizabeth Henry, APRN
Katie Grigg, APRN
Stephanie Adams, APRN

Authorization to Release or Obtain Patient Identifiable Health Information (Excluding psychotherapy notes)

Patient Name: _____ Date of Birth: _____

-I <u>authorize Flanders Pediatrics LLC</u>, to release or obtain the above named individuals health information as described below.

-The type of information to be obtained or released is as follows (include dates where appropriate).

_____ DIAGNOSIS AND TREATMENTS
_____PHYSICAL EXAMS AND GROWTH CHARTS
_____CONSULTATIONS
_____LABORATORY TESTS, X-RAYS, OPERATIVE NOTES, PATHOLOGY REPORTS
_____HOSPITAL ADMISSION REPORTS FROM_____TO_____
_____MOST RECENT DISCHARGE SUMMARY
_____OTHER (PLEASE SPECIFY) _____
_____IMMUNIZATION RECORDS
_____MEDICATION LIST
_____ENTIRE MEDICAL RECORD

This information may be obtained or released to the following individual or organization:

****PLEASE DO NOT SEND DOUBLE SIDED COPIES-THANK YOU! ****

Name: _____
Address: _____
Phone: _____ Fax: _____
For the purpose of: _____

-I understand that the cost for copying my health record will be $0.65 per page plus applicable postage. Payment must be made prior the record being released.

-I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome(AIDS), or human immunodeficiency virus(HIV). It may also include information about behavior or mental health services. I understand that I have the right to refuse to grant the consent to release this type of information.

-If any of the information to be released or obtained relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release this information as found in Part 2 of Title 42 of the Code of Federal Regulations(CFR), which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

-I understand that no psychotherapy notes may be disclosed unless I sign a separate authorization specifically to release psychotherapy notes.

-I understand that I have the right to revoke this authorization at any time. I must revoke this authorization in writing to the Privacy Officer at Flanders Pediatrics, LLC. I understand that the revocation will not apply to information that has previously been released. This revocation will not apply to my insurance company as the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

-I understand that I do not need to sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. 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. If I have questions about disclosure or my health information, I can contact the Privacy Officer. I acknowledge that I am signing this authorization freely, and no one has coerced or pressured me to sign the authorization.

_____ _____
Signature of patient or Parent/Guardian **Date signed**

305 Flanders Road PO Box 278
East Lyme, CT 06333
Phone: (860) 739-0348 Fax: (860) 739-6779
www.flanderspediatrics.com

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