AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

Address: _____ **City/State/Zip**: _____

Please Do Not fax charts more than 50 pages, send via email to info@cvpeds.com or mail to our office.

Please do not send on a USB Device or CD.

Above listed patient authorizes to release medical records **FROM**:

Facility Name _____ **Phone:** _____
Address: _____
City/State/Zip _____**Fax:**_____

Type of Information to disclose: ___Immunizations ___Most Recent Well Visit ___Other_____

___Medication List ___Problem List ____Growth Charts

The purpose of disclosure is: ___Change of insurance ___Change of Physician ___Referral ___Other_____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

I understand I may revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. **Unless otherwise specified or revoked, this authorization will expire one year from the date signed, or if I am a minor, on the date I turn 18 years of age.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. 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.

X_____ _____

Signature of Patient or Authorized Personal Representative Date

_____ _____

Printed name of Authorized Representative Relationship to Patient

_____

Address and telephone number of authorized representative