Authorization for Disclosure of Patient Information

sfbay pediatrics

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Patient Name:_____ Date of Birth:_____
Address:_____
Telephone Number:_____
I hereby authorize _____
(Facility/Provider Name and Location)
to release information from the medical record of _____
(Patient Name)

The following information may be released:

- ☐ All pertinent records
- ☐ Records from the last _____ year(s), including progress notes, immunizations, labs, x-ray reports & consult notes
- ☐ Lab reports – date(s)
- ☐ X-Ray report(s)
- ☐ Progress Notes – date(s)
- ☐ Other (please specify) _____

Release for the following purpose:

- ☐ Legal
- ☐ Insurance
- ☐ Patient Request
- ☐ New Pediatrician
- ☐ Other (please specify)

_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I hereby *specifically* authorize the release of data and information relating to: (check any that apply)

- ☐ HIV/AIDS related testing
- ☐ Mental Health
- ☐ Chemical Dependency (Drug/Alcohol)

This information may be disclosed to and used by the following individual or organization:
Name:_____
Address:_____
Telephone Number:_____ Fax Number:_____

This authorization will be valid for 180 days from the date it is signed or until _____, whichever is shorter. This authorization may be received at any time by notifying the above named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Information used and disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

_____
Signature of Patient or Legal Guardian
(Parent/Legal Guardian must sign if patient is a minor)

Date:_____

_____
Relationship to patient, if not the patient

For Office Use Only:
Copied by:_____ Date:_____
To be sent/mailed ☐
To be picked up ☐
Date sent/mailed:_____
*Approved for release by M.D.*_____