



Pediatric Associates of Lewiston, P.A.

33 Mollison Way * Lewiston, Maine 04240
Tel. (207) 784-5782 *Fax. (207) 783-9268

AUTHORIZATION TO RELEASE/DISCUSS HEALTHCARE INFORMATION

Patient Name: _____ DOB: _____

I, _____, residing at _____
Phone _____

Authorize release of information from: _____
Address: _____

Information to be released/discussed to: *Pediatric Associates of Lewiston P.A.*
Address: *33 Mollison Way, Lewiston Maine 04240*

PURPOSE OF RELEASE (please check one):

Changing Physicians (reason for transfer) _____ Legal Other _____
Although it will be requested, I understand confidentiality at the receiving end cannot be guaranteed.

TYPE OF INFORMATION TO BE RELEASED:

General Medical Records - excluding protected material
 Specific Information Only: _____
 Other Practitioners Records
 Other: _____

PROTECTED OR SENSITIVE INFORMATION:

I understand that certain information cannot be released without specific authorization as required by law.
By initialing, I authorize release of the following protected information:

____ Mental Health Information:
____ Drug Abuse/Alcoholism Information
____ AIDS/HIV Test results- including high risk behavior
____ Other sexual information such as dysfunction or related diseases

I UNDERSTAND THAT:

**I can revoke my consent at any time prior to the release of records by delivering a written, signed and dated notice of my wish to Pediatric Associates.
**I can refuse to disclose some or all of my records, but if I do so, it could result in any improper diagnosis or treatment, denial of coverage of a claim for health benefits or other adverse consequences. Incomplete records may be labeled to inform the receiving of their status.
** This consent for is
**I can edit and/or obtain a copy of this release upon request.

Signature of Parent/Guardian or Authorized Representative

Date

Print Name

Relationship