



Pediatric Associates of Lewiston, P.A.

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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: _____

Address: _____

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