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**Authorization to Release Information**

Patients Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ SS#: \_\_\_\_\_

I authorize (please print name of previous Doctor or Facility \_\_\_\_\_) to disclose above named individual's health information. (only checked boxes below) to Excel Pediatrics. Please give phone and fax numbers if available.

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Problem List ( )

Most recent Discharge Summary ( )

Medication List ( )

Laboratory Results ( ) Date: \_\_\_\_\_

List Of Allergies ( )

X-Ray and Imaging Reports ( ) Date: \_\_\_\_\_

Immunization Record ( )

Consultation Reports ( ) From: \_\_\_\_\_

Most recent History & Physical ( )

Designated Record Set ( )

I understand that the information in my health record may include information relating to sexually transmitted diseases. AIDS, and HIV. Included may also be information about behavioral or mental health services, and treatment for drug and alcohol abuse.

I understand that I have the right to revoke authorization at any time. Understanding that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The authorization will expire in six months unless otherwise dated here. \_\_\_/\_\_\_/\_\_\_.

I understand that authorizing disclosure of health information is voluntary. Refusing to sign this authorization is your choice. I need not sign this form in order to ensure 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.

\_\_\_\_\_  
Signature of Parent, Guardian or Self

Date: \_\_\_\_\_

\_\_\_\_\_  
Witness

Date: \_\_\_\_\_