

Authorization For Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information may no longer be protected by federal privacy regulations and that it may be re-disclosed by the recipient.

Patient (s) Name(s) and Dates of Birth: _____

Organization Providing the Information: _____

Organization(s) or Person(s) Receiving the Information: _____

Specific Description of Information Disclosed: _____

To the extent any of the following information is contained in my records being released, I specifically authorize the release of such information purposes indicated below by initialing before each category:

Initials: _____ HIV/AIDS testing, test results, treatment and related information including high risk behavior documented:

Initials: _____ drug and /or alcohol diagnosis, treatment, test results and reports and referral information;

Initials: _____ mental health treatment information, test results and reports including psychological and psychological and psychiatric studies, reports, evaluations and referral information; and/or

Initials: _____ venereal disease information;

Initials: _____ genetic testing, test results, counseling, reports, treatment, and referral information.

Purpose of Discloser: New insurance
 Transfer adult physician
 Moving to _____
 Other (specify) _____

You must read and initial the following statements:

1. I understand this Authorization will expire one year from date below OR on ____/____/____
Or on the following event: Termination of the Physician/Patient relationship. **Initials:** _____

2. I understand that I may revoke this Authorization at any time by notifying Watchung Pediatrics' Privacy Officer in writing, but if I do, it will not have any effect on any actions Watchung Pediatrics took before they received the revocation. **Initials:** _____

Charge:

Watchung Pediatrics charges a \$25 medical records transfer fee, *per child*, payable at the time the request is submitted.

Signature of Patient or Representative and Relationship

Date

*You may refuse to sign this authorization. We cannot condition **treatment** on your signing this Authorization.*