Children's Development Center, P.A.

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"Helping Children With Life's Ups and Downs"

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

______________________________ Name of Patient

______________________________ Birth Date

______________________________ Street Address

______________________________ City, State, Zip Code

I hereby authorize:

______________________________ Name

______________________________ Street Address

______________________________ City, State, Zip Code

To disclose any protected health information, as described below is:

______________________________ Name

______________________________ Street Address

______________________________ City, State, Zip Code

Information to be released:

_____ Medical History, Examination Reports
_____ Treatment of Tests
_____ X-ray Reports
_____ Laboratory Reports
_____ HIV Test Results*
_____ Mental Health
_____ Sexually Transmitted Disease
_____ Alcoholism
_____ Surgical Reports
_____ Hospital Records including papers
_____ Developmental Disabilities
_____ Prescriptions
_____ Consultations
_____ Allergy Records
_____ Drug Abuse
_____ Other (Please Specify)_________________

* A listing of the statutory exceptions to release of HIV test results without consent is available.

Purpose for Need of Disclosure

_________ At the request of the individual

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I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

- Receive Copy of This Authorization.
- Refuse to Sign This Authorization and that treatment payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this subornation???
- Revoke This Authorization, except to the extent that this person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s):______________________________

______________________________ Signature of Patient [or Legal Representative]

______________ Date

If signed by Legal Representative:

______________________________ Relationship to Patient [or Legal Representative]

______________ Date