



HAYWOOD PEDIATRIC & ADOLESCENT MEDICINE GROUP, P.A.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hereby authorize (please include address & phone & fax number if known):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

to disclose the following information from the health records of:

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

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

2. Information to be disclosed (Please check all that apply):

- Complete Health Record(s) for the last 3 years or period spanning \_\_\_\_\_
- Immunization Records  Newborn Records
- History & Physical Examination  X-Ray Reports
- Laboratory Tests  Specific Date of Service \_\_\_\_\_
- Other (Please Specify) \_\_\_\_\_

I understand that this will include information relating to acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) infection, behavioral health service/psychiatric care, and treatment for alcohol &/or drug abuse. If you wish to exclude any of the above please specify

\_\_\_\_\_

3. This information will be disclosed to (please include address & phone & fax number if known):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For the purpose of: \_\_\_\_\_

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this release is valid for one year after signature date.

5. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Relationship to patient: \_\_\_\_\_