



HAYWOOD PEDIATRIC & ADOLESCENT MEDICINE GROUP, P.A.
15 Facility Dr
Clyde, NC 28721
828-452-2211 (P) 828-452-4421 (F)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hereby authorize Haywood Pediatric & Adolescent Medicine Group, P.A. 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 10 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 _____.

I request this information be released in the following format (please *initial* ONLY ONE):

Paper Copy Fax CD Online Portal (please enter a valid email) _____

3. This information will be disclosed to (if requesting fax please enter fax number, if requesting records mailed please enter complete mailing address)

For the purpose of: Personal Records Transfer to another practice Other _____

4. I understand that Haywood Pediatrics cannot make me sign this authorization as a condition to receive treatment except:
(a) When Haywood Pediatrics provides me with research-related treatment; or
(b) When Haywood Pediatrics provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
5. 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.
6. 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.

Printed Name: _____ Signature: _____

Relationship to patient: _____ Date: _____