AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION	
Patient Name:	**Date of Birth:**
Social Security No:	**Telephone No:**
Address:	

RELEASE TO	
I authorize **DE LA VEGA PEDIATRICS**; **to release** the health information indicated below to: **And** for the purpose of alternative means of confidential communication the use of the following Email Address:	
Person/Organization Name:	
Address:	
Telephone No:	**Email Address:**
Dates of Medical Record Release:	

DE LA VEGA PEDIATRICS., (DVP) offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **DVP** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **DVP** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and I consent to the conditions outlined herein. Any questions I may have had were answered.

REASON FOR DISCLOSURE		
☐ **Continuing Care**	☐ **Legal**	☐ **Other Purpose** *(please specify)*
☐ **Insurance**	☐ **Personal Use**	

INFORMATION TO BE RELEASED	
☐ **Complete Medical Record**	☐ **Operative Reports**
☐ **Lab Reports**	☐ **Pathology *Reports***
☐ **Radiology Reports**	☐
☐	☐
☐ **Other** *(please specify)*	

SPECIFIC AUTHORIZATIONS	
The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:	
☐ **Drug/Alcohol Abuse or Treatment**	☐ **Genetic Testing Information**
☐ **HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses**	☐ **Mental Health Treatment or Psychotherapy Notes** *(The release of Psychotherapy Notes require a separate authorization)*

This consent is subject to revocation at any time except to the extent the action has been taken thereon. ***This authorization and consent will expire one year from the date of authorization written below.*** Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

Patient Signature: *(Guardian/Legal Representative)*	**Date Signed:**
Print Name: *(Please Print)*	**Relationship If Other Than Patient:**

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care).*