**RELEASE OF INFORMATION**

|  |  |
| --- | --- |
| NAME: | DOB: |
| PARENT/GUADIAN: | RELATIONSHIP: |
| ADDRESS: | APT: |
| CITY/STATE: | ZIP CODE: |
| **INFORMATION RELEASED FROM** | **INFORMATION RELEASED TO** |
| NAME: | NAME: |
| ADDRESS: | ADDRESS: |
| CITY/STATE/ZIP: | CITY/STATE/ZIP: |
| PHONE: | PHONE: |
| FAX: | FAX: |

Reciprocal Authorization for Release of Information (Check if Applicable)

\_\_\_\_\_\_\_\_\_\_\_\_ A reciprocal authorization allows Beahvioral & Developmental Pedaitrics to have continuous dialogue between the provider and staff of Behavioral and Developmental Pediatrics and the individual/group listed above.

Description of Information to be Released (Check if applicable).

\_\_\_\_\_ Complete Medical Record  \_\_\_\_\_Psycho-educational testing \_\_\_\_\_ Record of Psychiatric Hospitalization

\_\_\_\_\_ Diagnostic/Lab Testing      \_\_\_\_\_Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Regarding services rendered during the following dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Purpose of Release of Record (check one)**

\_\_\_\_\_Continuing treatment \_\_\_\_\_Personal \_\_\_\_\_Legal Involvement \_\_\_\_\_Moving \_\_\_\_\_Insurance

\_\_\_\_\_ Other (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_).

Confidential information relative to a patient with HIV infection or AIDS shall only be released in accordance with G.S 130A-143

I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recpients of that information.  I specifically authorize any medical personnel of Beahvioral and Developemntal Pediatrics or any other individuals listed abouve to disclose my protected health information as described on  this form to the recipeints listed.  I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclose by the recipient and may no longer be protected health information.  I further understand that I retain the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable during a contestability period.  This authorization shall be valid for one year from signature.  I hereby release Behavioral snd Developmental Pedaitrcs from all legal responsibility and liability ythat may arise form this authorization.

Patient/Legal Guardian Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_