RIVER RIDGE PEDIATRICS

AUTHORIZATION FOR RELEASE (DISCLOSURE) OF PATIENT HEALTH INFORMATION

Patient information:

Patient's Name:		Address:	
SSN:		City/State/ Zip:	
Date of Birth:		Telephone #:	

Release from: (Authorized person/agency to release information):

Physician/ Agency Name:		Address:	
Telephone #:		City/State/ Zip:	

Released to: (Who will receive the information)

Physician/ Agency Name:		Address:	
Telephone #:		City/State/ Zip:	

Type of Information to be released: (Please specify)

Initial and date the following consent:
I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records. _____ Initial _____Date

Reason for Disclosure:

PROHIBITION OF RE-DISCLOSURE: Federal confidentiality laws protect this information. Such laws prohibit the re-disclosure of such information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by such laws. However, I understand that the information disclosed may potentially be re-disclosed by the recipient and may no longer be protected by the federal privacy and confidentiality rules.

I have had an opportunity to review and understand the content of this Authorization. I understand that I have the right to revoke this authorization at any time. I can do so by submitting my revocation in writing to the clinic. I understand that my revocation will not apply to information that has already been released in response to this authorization.

By signing this Authorization, I am confirming that it accurately reflects my wishes. A photocopy or facsimile of this Authorization is as valid as the original.

_____

Patient/Legal Guardian Signature Date Relationship to Patient