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CONSENT TO RELEASE PRIVATE HEALTH INFORMATION

By signing this authorization, I authorize Mendon Pediatrics, to use and/or disclose certain protected health information about _________________________ to:

____
____
Phone: ___________________________

This authorization permits Mendon Pediatrics to use and/or disclose the following individually identifiable health information:

___ Complete Medical Records
___ Medication List
___ Last Physical
___ Immunizations
___ Lab reports
___ Developmental Issues
___ HIV/AIDS Information
___ Drug/Alcohol Information
___ Mental Health Information
___ Other Confidential Information

The information will be disclosed for the following purpose: _______________________________________
____

If requested by the patient, purpose may be listed as diagnosis being treated or "continuity of care".

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on ______________ (max 1 year).

I have the right to revoke this authorization at any time. I must do this in writing to Mendon Pediatrics, PLLC at the above address.

Signed by: ____
(signature of patient if over 18) or (guardian/parent)

Relationship to patient: ____

________________________________ Print patient's name

_____________________________ Print name of guardian/parent

______________ Date