

# FLANDERS PEDIATRICS, LLC

131 BOSTON POST ROAD, EAST LYME, CT 06333-0278

## AUTHORIZATION FOR RELEASE or OBTAIN OF PATIENT IDENTIFIABLE HEALTH INFORMATION (Excluding psychotherapy notes)

PATIENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

1. I authorize Flanders Pediatrics, LLC, to OBTAIN and or RELEASE the above named individuals health information as described below.
2. The type of information to be obtained or released is as follows (include dates where appropriate).

\_\_\_\_\_ DIAGNOSIS AND TREATMENTS  
\_\_\_\_\_ PHYSICAL EXAMS AND GROWTH CURVES  
\_\_\_\_\_ CONSULTATIONS  
\_\_\_\_\_ LABORATORY TEST, X-RAYS, OP NOTES, PATHOLOGY REPORTS  
\_\_\_\_\_ HOSPITAL ADMISSIONS REPORTS FROM \_\_\_\_\_ TO \_\_\_\_\_  
\_\_\_\_\_ MOST RECENT DISCHARGE SUMMARY  
\_\_\_\_\_ OTHER (MUST SPECIFY)  
\_\_\_\_\_ IMMUNIZATION RECORDS  
\_\_\_\_\_ MEDICATION LIST

3. This information may be obtained from or released to the following individual or organization:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

For the Purpose of: \_\_\_\_\_

4. I understand that the information in my health record may include information relating to acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services. I understand that I may refuse to grant the consent to release this type of information.
5. If any of the information to be released and or obtained relates to treatment for alcohol and drug abuse, I understand that there are special requirements for my consent to release as found in Part 2 of Title 42 of the Code of Federal Regulations (CFR), which prohibits the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.
6. I understand that no psychotherapy notes may be disclosed by my signing this authorization and that a separate authorization would be required for the release of psychotherapy notes.
7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Officer at Flanders pediatrics, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
8. I understand that I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provide in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Health Information Officer. I acknowledge that I am signing this authorization freely, and no one has coerced or pressured me to sign the authorization.

Signature of Parent or Guardian: \_\_\_\_\_ Date \_\_\_\_\_