Patients 18yr and older -Authorization for Release of Protected Health Information

1. Patient Information:

Patient's Name: _____ **Patient's Date of Birth: _____**
Patient's Address:_____ **Patient's Cell Number:_____**

Name of Primary Care Doctor: _____

I hereby authorize and consent to disclosure of health records as stated below. I am aware that the records disclosed might contain records whose confidentiality is protected by either the Federal Drug & Alcohol Confidentiality Law (42 C.F.R. Part 2) or the State Mental Health Records Law (I.C. 16-39-2). I understand the records released may include alcohol and/or substance abuse, mental health and communicable disease documentation (including HIV results) unless I specifically prohibit the release of this information.

2.
_____ a. I authorize All Star Pediatrics and Sports Medicine, PC to release records to my parents / guardians.

Please list parent / guardian names here:_____

List what items you DO NOT want to be released here:
_____

_____ b. I do not authorize All Star Pediatrics and Sports Medicine, PC to release records to my parents / guardians.

3. This request may be revoked by the patient at any time by communicating in writing that intent to the provider.

4. I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. However will make me responsible for my account at All Star Pediatrics and Sports Medicine, PC.

PATIENTS 18 YEARS AND OLDER, ARE HIS/HER OWN LEGAL GUARDIAN AND MUST SIGN THIS FORM TO RELEASE MEDICAL RECORDS INFORMATION.

_____ _____ _____
Patient Signature **Printed Name** **Date Signed**