Helotes pediatrics

Release of Medical Information

Patient Name: _____ DOB: ___/_____/_____

I authorize Helotes Pediatrics PA to disclose the following:

_____ All of my medical-related information.

_____ My medical information ONLY related to: _____

_____ My medical-related information from
_____, 20_____ to _____, 20_____

Hereinafter known as the "Medical Records".

Helotes Pediatrics has my authorization to disclose Medical Records to:

_____ Any party that is approved by Helotes Pediatrics PA.

_____ ONLY the following party

Name: _____

Address: _____

Phone: (____) _____-_____ Fax(____) _____-_____

Email: _____

Please state the reason for this authorization: _____

_____

_____

This authorization will terminate on:

_____ Upon sending a written revocation to Helotes Pediatrics.

_____ On the following date: ___/____, 20_____

_____ Other _____

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I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

Printed Name: _____

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ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

1. **SENSITIVE INFORMATION:** This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

Check one:

_____ **I consent** to have the above information released.

_____ **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ Date: _____

Printed Name: _____

2. **HIV / AIDS:** This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

Check one:

_____ **I consent** to have the above information released.

_____ **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ Date: _____

Printed Name: _____