PEDIATRIC ASSOCIATES
OF WATERTOWN
THRIVE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
PARENTS/MINORS AGE 13-17 yrs

PLEASE READ ALL INFORMATION AND INSTRUCTIONS BEFORE COMPLETING AND SIGNING THIS FORM

PATIENT NAME:_____ **DOB:**____/____/____

INFORMATION TO BE RELEASED **BY:**_____

_____
ORGANIZATION/PERSON NAME

_____
ADDRESS

_____
PHONE FAX

INFORMATION TO BE RELEASED **TO:**_____

_____
ORGANIZATION/PERSON NAME

_____
ADDRESS

_____
PHONE FAX

TYPE OF MEDICAL INFORMATION REQUESTED:

☐ Complete Medical Record, including Growth Chart & Immunizations
☐ Health Information related to following treatment or condition:_____
☐ Health Information only for the following dates:_____
☐ Other:_____

REASON FOR REQUEST: ☐ Personal ☐ Transfer of Care ☐ Continuing Care ☐ Legal Review

☐ Other (please explain)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded below:

_____

MINORS AGE 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care including, but not limited to: contraception, pregnancy and pregnancy termination, sterilization and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and mental health conditions (age 13 and older).

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD

This authorization expires on _____(Date or Event). Authorization will expire in one year if not otherwise specified.

Patient Signature:_____ **Date:**_____

Printed Name:_____

Parent or Legal Guardian Signature:_____ **Date:**_____

Printed Name:_____ **Relationship to Patient:**_____