ASHEVILLE Pediatric ASSOCIATES, P.A.

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Authorization for Disclosure of Health Information
(Autorización para utilizar o divulgar su Información de Salud)

1. I hereby authorize the disclosure of the following information from the health records of :
(Autorizo la divulgación de la siguiente información de los registros de salud de):

Patient's Name*/(Nombre del Paciente)*: _____ DOB*(Fecha de nacimiento)*: _____

Address*/(Direccion)*: _____ Phone #: _____

_____

Covering the period(s) of health care from _____ to _____

2. This information will be disclosed

To: **Asheville Pediatric Associates**
2 Medical Park Drive
Suite 1000
Asheville, NC 28803
Phone: 828-254-5326 / Fax: 828-251-5954

From:
_____
Name of Office
_____
Address
_____
City State Zip
_____ / _____
Phone # Fax #

For the purpose of _____

3. Information to be disclosed:

- ☐ History & Physical Examination/ Well-Child Visits
- ☐ Consultation Reports
- ☐ X-ray Reports
- ☐ Immunizations
- ☐ Discharge Summary/ Specialists Notes
- ☐ Problem & Medicine Lists
- ☐ Laboratory Tests
- ☐ Other (Please Specify):_____

I understand that this will include information relating to (check if applicable):

- ☐ Acquired Immunodeficiency Syndrome (AIDS)
- ☐ Human Immunodeficiency Virus (HIV) infection
- ☐ Behavioral health service/psychiatric care
- ☐ Treatment for alcohol and/or drug abuse

4. I understand this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition.

5. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Relationship to Patient: _____

Signature of Witness: _____ Date: _____

******PLEASE SEE OTHER SIDE FOR MEDICAL RECORDS FEES*******