HAYWOOD PEDIATRIC & ADOLESCENT MEDICINE GROUP, P.A.
15 Facility Dr
Clyde, NC 28721
828-452-2211 (P) 855-732-4561 (F)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hereby authorize **Haywood Pediatric & Adolescent Medicine Group, P.A.** to disclose the following information from the health records of:

   Patient Name: _____ Date of Birth: _____

   Address: _____ Telephone: _____

2. Information to be disclosed (Please check all that apply):

   ___ Standard Release for the last 5 years **OR** period spanning _____
   ___ Summary of visits/face sheet only ___ Laboratory Tests
   ___ Immunization Records ___ Newborn Records
   ___ History & Physical Examination ___ Specific Date of Service _____
   __ Other (please specify)_____

   I understand that this may include information relating to acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) infection, behavioral health service/psychiatric care, and treatment for alcohol &/or drug abuse. If you wish to exclude any of the above please specify _____

   I request this information be released in the following format (please *initial* **ONLY ONE**):

   _____ **Fax** (please enter valid fax number) _____

   _____**EMAIL** (please enter a valid email) _____

   _____ **Paper/printed copy:**

   Authorized pick-up person _____

   (or) Mailed to (please enter complete mailing address) _____

   _____

   For the purpose of: ___ Personal Records ___Transfer to another practice ___ Other _____

3. I understand that Haywood Pediatrics cannot make me sign this authorization as a condition to receive treatment except:
   (a) When Haywood Pediatrics provides me with research-related treatment; or
   (b) When Haywood Pediatrics provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

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 release is valid for one year after signature date.

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.

   Printed Name: _____ Signature: _____

   Relationship to patient: _____ Date: _____

(Office Use Only)

Identification Verified by_____ **Date**_____