HAYWOOD PEDIATRIC & ADOLESCENT MEDICINE GROUP, P.A.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hereby authorize (please include address & phone & fax number if known):
   _____
   _____
   _____
   to disclose the following information from the health records of:

   Name: _____ Date of Birth: _____

   Address: _____ Telephone: _____

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

   ___ Complete Health Record(s) for the last 6 years or period spanning _____
   ___ Immunization Records
   ___ History & Physical Examination
   ___ Laboratory Tests
   ___ Other (Please Specify) _____
   ___ Newborn Records
   ___ X-Ray Reports
   ___ Specific Date of Service _____

   I understand that this will 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
   _____.

3. **This information will be disclosed / sent to**:

   Haywood Pediatrics, **Attention Medical Records 15 Facility Dr., Clyde, NC 28721**

   Phone: (828) 452-2211 Ext. 1124 / Fax: (855) 732-4561

   For the purpose of: _____

4. 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.

5. 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.

6. 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 _____