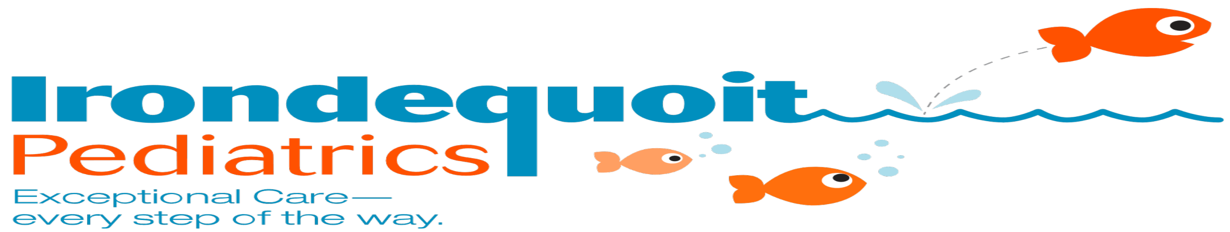

Permission Regarding Communication and Treatment

Patient Name: ____Date of Birth___________________

The following individuals will be added to the HIPAA Communication Section of the chart. I Acknowledge that I have already signed permission to release information as specifically stated on the designated section of the electronic chart and these stated methods will apply to these individuals.

Name of Individual: ____

Relationship to Patient:____

Telephone Number: ____

I, the undesigned parent/guardian of the above-named patient hereby empower and grant permission to the above-named individual to give consent to and authorize medical treatment. This authorization will include all medical treatments and procedures, and access to applicable medical information unless specifically indicated below.

I understand that certain information cannot be released without specific authorization required by law. By **initialing** below, I authorize the release of the following protected information:

___________Drug and/or Alcohol Treatment

___________Mental Health related information

___________HIV related information

This authorization allows Irondequoit Pediatrics to obtain information from, or disclose information to, the providers/facilities listed below. This could include your medical information as well as information regarding Drug and/or Alcohol Treatment, Mental Health related information and HIV related information.

This authorization shall be valid for the period commencing on _____________and ending on____________.

I do hereby indemnify and hold harmless the physicians and other persons who act in reliance upon this authorization.

Parent/Guardian____ Date_____________________

Patient____Date_____________________

Witness____