Irondequoit Pediatrics
Exceptional Care—
every step of the way.

Authorization For Release of Medical And/Or Behavioral Health Information

Patient Name: _____Date of Birth_____

This authorization allows Irondequoit Pediatrics to obtain information from, or disclose information to, the individuals/organizations 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.

Name of Individual: _____

Relationship to Patient:_____

Address:_____

Telephone Number: _____

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

Excluded Medical/Behavior Health 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.

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

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

Parent/Guardian_____ Date_____

Relationship to patient_____

Patient_____Date_____

Witness_____Date_____