Authorization for Lakewood Pediatric Associates, PLLC to
RECEIVE OR RELEASE MEDICAL INFORMATION

Patient Information:

_____ Birth Date_____
(PRINT name of patient)

Information to be released from:

_____
Name of Facility or Provider

_____
Address

_____ (_____)_____
City, State, Zip Code Phone Number

Information to be sent to:

_____
Name of Recipient

_____
Address

_____ (_____)_____
City, State, Zip Code Phone Number

Information to be released:

☐ All medical records

☐ Specific Information (please specify):_____

_____

Purpose for which disclosure is being made (please check **one** of the following):

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following from the records released (please initial):

_____ Drug/Alcohol abuse/treatment and diagnosis

_____ HIV/AIDS diagnosis/treatment/testing

_____ Sexually Transmitted Disease

_____ Mental Illness or Psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Notice of Privacy Practices posted at Lakewood Pediatric Associates. Once the health information I have authorized is disclosed, the person or organization that receives it may redisclose it. Privacy laws may no longer protect it.

_____ _____
Parent or Guardian Signature Patient Signature if age 14 years or older

_____ _____
Printed Name of Parent or Guardian Date

This authorization will expire 90 days from the date signed.

Possible copying fees required.

FORM#LWPRINT051010