NORTH SHORE PEDIATRICS

AUTHORIZATION FOR RELEASE (DISCLOSURE) OF PATIENT HEALTH INFORMATION:

Patient Information:

Patient's Name: _____
Date of Birth: _____ SSN: _____
Address: _____
City/State/Zip: _____ Telephone #: _____
Alternate Telephone #: _____

Release from: (Authorized person/agency to release information)

Physician/Practice Name: _____
Address: _____
City/State/Zip: _____ Telephone #: _____
Fax #: _____

Released to: (Who will receive the information)

Name: **NORTH SHORE PEDIATRICS** _____
Address: 924 WEST LITTLE CREEK ROAD _____
City/State/Zip: NORFOLK, VA 23505 Telephone #: (757) 440-0719 Fax#: (757) 440-7981

Type of Information to be released: (Please specify)

- ❑ Medical Record Set (includes Progress Notes/Well-Child Visits, Growth Charts, History & Physicals, Immunization Records and past 6 mos. Lab/X-Ray Results
- ❑ Progress Notes ❑ History /Physicals ❑ Immunizations
- ❑ Lab / X–Ray Reports ❑ Summary Of Clinic Records ❑ Growth Chart

The following sensitive information requires specific, initialed authorization:

- ❑ HIV/STD's _____ (Initials) ❑ Mental Health _____ (Initials)
- ❑ Alcohol/Drug _____ (Initials) ❑ Disability _____ (Initials)

Reason for Disclosure:

❑Transfer of care Reason: O Relocation O Insurance Change O Other (please specify)_____
❑Insurance Eligibility/Benefits ❑Legal Investigation ❑Personal Use ❑Other (specify)_____

Expiration Date:

This authorization is good until _____(date).
If no date is specified, this authorization will expire one (1) year from the date signed.

PROHIBITION ON RE-DISCLOSURE: Federal and Virginia confidentiality laws protect this information. Such laws prohibit the re-disclosure of such information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by such laws. However, I understand that the information disclosed may potentially be re-disclosed by the receipt and may no longer be protected by the federal privacy and confidentiality rules.

I have had an opportunity to review and understand the content of this Authorization. I understand that this Authorization is voluntary. NORTH SHORE PEDIATRICS will not condition your treatment, payment, and enrollment in a health plan or eligibility for health care benefits based on my decision to sign this Authorization.

I understand that I have the right to revoke this authorization at anytime. I can do so by submitting my revocation in writing to the clinic. I understand that my revocation will not apply to information that has already been released in response to this authorization.

By signing this Authorization, I am confirming that it accurately reflects my wishes. A photocopy or facsimile of this Authorization is as valid as the original.

_____ _____
Patient/Legal Guardian Signature Witness Signature (when applicable)

_____ _____
Date of Signature Date of Signature

_____ _____
Relationship to Patient Relationship