Montgomery Pediatrics, Inc.

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

For patients age 18 and older to parent, guardian or other individuals

I hereby authorize Montgomery Pediatrics, Inc. and its agents to release information regarding:

_____ (Name of Patient) _____ (Date of Birth)

_____ (Email Address) _____ (Telephone)

□ Release to □ Discuss With

_____ (Name of Individual) _____ (Relationship)

_____ (Address) _____ (City, State, Zip)

_____ (Email Address) _____ (Telephone)

I understand that by signing this agreement, I am authorizing the person named above to access my complete medical record including patient histories, office notes (including psychotherapy notes, test results, radiology studies, films, referrals, consults, billing records, and insurance records). My medical record may include information related to alcoholism and/or drug abuse or dependency, mental health/rehabilitation, or HIV and/or AIDS diagnosis and treatment unless otherwise excluded below.

I understand that I have the right to revoke this authorization at any time by presenting revocation in writing to Montgomery Pediatrics at the above address; however, revocation will not apply to information that has already been disclosed in response to this authorization prior to the revocation date. Unless otherwise revoked, this authorization will remain in effect for one year after the date signed.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

Exclude: (Initial all that apply)

_____ Information related to diagnosis and treatment for alcoholism and/or drug abuse or dependency

_____ Information related to diagnosis and treatment for mental health/rehabilitation

_____ Information related to HIV antibody test results and/or AIDS diagnosis and treatment

I, the undersigned, authorize Montgomery Pediatrics to use and/or disclose information from my medical or financial record as specified above.

_____ (Date)

_____ (Printed Name of Patient)

_____ (Signature of Patient)