Clinical Pediatric Associates
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Authorization for Release of Private Health Information & Treatment

Date: _____

Patient Name: _____ DOB: _____

Address: _____

Patient's Phone #: _____

For the Patient Portal, please write your e-mail below:

_____

I authorize Clinical Pediatrics to release my medical and/or billing information to the following individual(s):

Name: _____ Relation to Patient:_____

Name: _____ Relation to Patient:_____

☐ Release all medical information

Exceptions (Information NOT to be released) check all that apply:

☐ History & Physical Exams

☐ Medication Records

☐ Laboratory Reports/Tests

☐ Mental Health Records

☐ Specialists Reports

☐ Hospital Visits

By signing I am authorizing any medical information on the above named patient to be released. I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. The purpose for which this information is being released is for medical care of myself. I also request and authorize Clinical Pediatric Associates and its personnel to deliver medical care to myself as may be deemed necessary or advisable. Medical care and interventions may include but are not limited to: medical evaluation, physical exam, routine immunizations, injections, and lab work (examples: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, minor burns, and suturing of lacerations). I have read, understand, and give my consent to be treated and have my medical records released as stipulated above.

Signed: _____ Date: _____