Alger Pediatrics release of information form

**Please note: this form must be completed and signed by the parent/guardian.*

Patient's name: _____ **Patient's date of birth:** _____

I understand and acknowledge that any party besides the parent/guardian will not be permitted to receive medical information regarding the patient, schedule appointments for the patient, or speak with the office regarding the patient without my written consent in accordance with this document.

☐ I wish to grant the below person(s) access to some or all of my child's medical information.

Name: _____

Relationship to patient: _____

Phone number: _____

I wish to grant the person(s) named above access to the following medical information:

☐ All medical information, including all records listed below.

- ☐ Office notes
- ☐ Lab results; pathology reports
- ☐ X-rays
- ☐ Financial history report
- ☐ Nursing home, home health, hospice, and other physician records
- ☐ Mental health records
- ☐ Record of communicable disease testing (including HIV)
- ☐ Alcohol/drug abuse treatment
- ☐ Only share the following information:

  _____

This authorization is valid for one year from the date signed, unless an earlier termination date is specified. This authorization may be revoked in writing at any time. Alger Pediatrics does not require this authorization as a condition for the delivery of healthcare or treatment. There is potential that information disclosed in this authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA).

Parent/guardian signature: _____ **Date signed:** _____