GROW Pediatrics & Adolescent Medicine, PLLC
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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:
Date of Birth:	Contact Number:	
Street Address:	City, State, & Zip Code:	

INFORMATION TO BE RELEASED FROM:

_____ GROW Pediatrics

_____ Other:

Organization/Person:

Address:	
Phone:	Fax:

INFORMATION TO BE RELEASED TO:

_____ GROW Pediatrics

_____ Other:

Organization/Person:

Address:	
Phone:	Fax:

PURPOSE OF RELEASE

_____ Legal _____ Personal Use _____ Continuing Care _____ Transfer to Another Provider _____ School _____ Other:

AUTHORIZATION FOR GENERAL RELEASE OF INFORMATION

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization any time by written notification to GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.
- This authorization will expire 90 days from the date signed below unless another date or event is entered here: _____

Sensitive records pertaining to the diagnosis and treatment of specifically protected or privileged categories require patient authorization. Please INITIAL which records you authorize us to release:

_____Drug/Alcohol abuse _____Sexually transmitted diseases _____Mental Health _____HIV/AIDS testing _____ Other:

SIGNATURE OF MINOR PATIENT REQUESTED FOR THE FOLLOWING RECORDS

A minor patient's signature is required to release the following information related to: 1) Reproductive care, such as birth control, pregnancy-related services, and sexually transmitted diseases, including HIV/AIDS (age 14 and older); 2) Substance abuse and mental health treatment (age 13 and older).

Signature of Minor Patient Date

SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE

Signature of Patient/Parent/Legal Representative Date

Printed Name of Parent/Legal Representative Relationship to Patient

A complete records request takes our office up to 14 business days to process. A record of more than 40 pages cannot be faxed and will be copied to a disc for mailing. As a courtesy, GROW Pediatrics fulfills one complete records request per patient at no charge with a $25 fee for any additional requests.