INDIVIDUAL PATIENT RELEASE FORM

Cape Cod Pediatrics
Authorization to use or disclose protected health information

I hereby authorize use or disclosure of the names individual's health information as described below:

Patient name: **date of birth:**

Address (street, city, state, zip code) **Phone number:**

The following individual or organization is authorized to make the disclosure:

- ☐ Cape Cod Pediatrics
- ☐ Other (please specify)_____

The information may be disclosed to and used by the following individual or organization:

- ☐ Schools/Daycare
- ☐ Camps
- ☐ Other (ie:pop warner, scouts, after school activities) _____

The following information may be disclosed:

- ☐ Immunization records
- ☐ Physician notes
- ☐ Lab results
- ☐ X-ray reports, MRI scans
- ☐ Complete record
- ☐ Other _____

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome(AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the study may be denied.
- I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire 12 months from date of signature.

Signature of patient or legal representative

_____ Date _____

Relationship to Patient

_____