CAPE COD PEDIATRICS

Release of Information
18 Years and Older

NAME____DATE OF BIRTH ____/____/____

I give consent for a copy of my most recent physical, which includes immunizations, to be released to the following:

☐School
☐Sports
☐Other **(PLEASE SPECIFY)**: ____
☐**DO NOT RELEASE**

☐ **Authorization for CCP to speak with the following regarding any BILLING issues:**

1)____

2)____

☐ **DO NOT AUTHORIZE**

☐ **Authorization to speak with the following regarding MEDICAL information, including but not limited to, appointments, prescriptions, labs, etc:**

1)____

2____

☐**DO NOT AUTHORIZE**

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information 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. 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 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.

Signature____ Date___/___/___

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED OR AMENDED