CAPE COD PEDIATRICS
Release of Information

NAME____ DATE OF BIRTH_______________________

I give consent for a copy of my/my child's most recent physical, which includes immunizations, to be released to the following:
☐School
☐Daycare
☐Other (Please specify) ____

The following may seek medical treatment at Cape Cod Pediatrics in my absence:
NAME RELATIONSHIP CONTACT NUMBER

____

____

____

******IF YOU ARE 18 YEARS OR OLDER, PLEASE COMPLETE THIS SECTION******

☐ BILLING: If you would like us to speak with anyone other than yourself regarding any billing issues. Name:____
☐ MEDICAL: If you would like us to speak with anyone regarding medical information contained in your chart, scheduling or acknowledging appointments, prescriptions, etc. Name: ____

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 nay be denied.
I understand that I may inspect or obtain a copy of the information to be used or disclosed

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN
____DATE____________
**If legal guardian, please provide office with current legal documentation

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED OR AMENDED