IVY PEDIATRICS, P.A.

Authorization to Release Medical Information

Patient's Name:_____ DOB:_____

Address:_____

1. I authorize the use or disclosure of the above named individual's health information, as described below.

2. The following individual or organizations are authorized to make the disclosure: IVY PEDIATRICS, PA.

3. The information may be disclosed to, and used by, the following individuals or organizations:

Name(s):_____

Address:_____

Email: _____

For the following purpose(s):_____

4. The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose(s) and may include the following items (unless crossed out by me).
   - Drug and Alcohol abuse information.
   - Information regarding Human Immunodeficiency Virus (HIV), including laboratory results.
   - Diagnosis of AIDS or ARC, if applicable.
   - History and Physical examination.
   - Consultations.
   - Genetic testing and counseling, if applicable.
   - Diagnostic testing, excluding HIV testing.
   - Discharge summary.
   - Psychosocial history.
   - Treatment recommendations.
   - Other(specify):_____
5. This authorization may be revoked by me at any time except to the extent that IVY PEDIATRICS has already acted in reliance on this authorization. If I revoke this authorization, I need to do so in writing and by email/ mail/Fax or hand deliver it. If not revoked by me, this consent will terminate on:_____.
6. I have a right to inspect the information to be disclosed.
7. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
8. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by this rule.
9. **There is no charge to email you the records. The copying fee is $10 for the first 15 pages and 50 cents for each additional page not to exceed $50. Records can be picked up in person or can be mailed (postage fee applies).**

Signature of Patient/Legal Representative:_____Relationship_____

Signature of Witness:_____

Date:_____

12/11/2023