AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Authorization to Disclose Information. I voluntarily authorize and direct After Hours Pediatrics, Inc. ("AHP") to disclose the health information of the above-named patient to the recipient identified as follows:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information to Be Disclosed. This authorization permits AHP to disclose the following medical records of the above-named patient:

☐ All health information that AHP has in its possession, including information relating to any medical history, mental or physical condition, any treatment received by the above-named patient, x-rays, HIV/AIDS status, STD results, genetic testing, psychotherapy notes, other mental health information, drug, alcohol, or other controlled substance information, billing information, correspondence, and records from other health care providers that AHP may possess.

☐ All of the health information described above, except for the following: _____

_____

_____

☐ Other: _____

_____

Term. This Authorization will remain in effect for one (1) year from the date this Authorization is signed.

Redisclosure. I understand that once AHP discloses the health information to the recipient identified above, AHP can no longer guarantee that the recipient will not re-disclose the health information to a third party. Such a third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of health information.

Photocopy & Facsimile. A photocopy or facsimile copy of this Authorization shall be considered as effective and as valid as the original.

Signature: _____ Witness Signature: _____

Printed Name: _____ Printed Name: _____

Relation to Patient: _____ Date: _____

Date: _____