Atlantic Adult & Pediatric Medicine

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of my health information as listed below:

Patient Name:_____ **Date of Birth:**_____

Address:_____ **Telephone #:**_____

_____

Person or Institution authorized to receive information: Atlantic Adult & Pediatric Medicine, 34435 KING STREET, SUITE ROW, LEWES, DE 19958

Phone Number: **302-644-1300** Fax Number: **302-644-1086**

Person or institution authorized to send information:_____

Address: _____Phone:_____Fax:_____

Description of Information:

- o Medical Record Abstract Entire Record Other_____

(Medical Record Abstract includes: Discharge Summary, Emergency Room Record, History and Physical, Operative Reports, Laboratory Reports, X-ray, Report)

Special Records: Medical Records to be released will not include records of drug and alcohol abuse program treatment, mental health records or STD, HIV, or generic information records unless the specific boxes below are checked. This information is protected by special laws. Checking the boxes is not a representation that such information exists.

- o Includes drug & alcohol records Includes HIV records Includes STD records
- o Includes genetic information records Include mental health records

Purpose of Release of Information:

- o Personal Use Medical Treatment/Management Legal Proceedings
- o Employment Related Purposes Insurance Related Other_____

1. This authorization will expire: Date:_____ Event:_____ One Year_____

Unless otherwise specified, this authorization will expired 90 days after the date of this request.

2. I understand that I may revoke this authorization at any time by notifying AAPM Privacy Coordinator in writing at 34435 King Street Row, Suite 1, Lewes, DE 19958. I understand that revocation will not have any effect on actions AAPM took before they received this revocation.
3. This authorization is voluntary. I understand that my treatment or payment for services will not be effected if I do not sign this authorization.
4. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations.

_____ _____ _____

Signature of Patient or Patient's Representative. Date Printed Name of Patient's Representative Relationship to Patient

To Recipient: Information regarding drug and/or alcohol use, abuse, treatment or referrals for treatment has been disclosed to you from records protected by Federal confidentially rules (43 CFR Part 2). The Federal rules prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.