WEST SIDE PEDIATRICS

AUTHORIZATION FOR RELEASE OF INFORMATION BY PATIENT OVER 18 YEARS OLD

I understand that it is the policy of West Side Pediatrics, Inc. (the Practice) to protect my privacy and to follow all state and federal privacy laws. However, I also understand in order to involve my parents or other individuals in my medical care it will be necessary for the Practice to use/disclose some of my Protected Health Information ("PHI"). I understand that my PHI to be disclosed may include information regarding genetic testing, HIV/AIDS status, mental health diagnosis and treatment and substance abuse diagnosis and treatment, pregnancies and/or pregnancy test results and I hereby specifically authorize the Practice to disclose such information to the persons listed below:

☐ I authorize West Side Pediatrics, Inc. to release and discuss my PHI including test and procedures to the following individuals:

Name: _____ Relation to Patient_____ Date_____

Name: _____Relation to Patient_____ Date_____

Name: _____Relation to Patient_____ Date_____

☐ I do not authorize West Side Pediatrics, Inc. to release or discuss my PHI with any family member.

PATIENT'S RIGHTS

I understand that I have the right to refuse to sign this Authorization to release my PHI. If I refuse to sign this Authorization, the Practice will in no way deny me my rights concerning treatment.

I understand that I may revoke this Authorization at any time after I have signed it by providing the Practice Manager with a written statement that I wish to revoke this Authorization. My revocation or Authorization will be effective immediately and my PHI will no longer be used /disclosed pursuant to this Authorization except when medically necessary in an emergency situation. This Authorization, unless I earlier revoke it, shall remain in effect for as long as I am an active patient at the Practice.

Patient _____
Please Print

Signature _____Date_____

Witness _____Date _____