

I authorize PAK PEDIATRICS to release information contained in the Medical Record of the patient named on this form. I understand the information may include the items initialed below (if it is contained in your/your child's medical record):

PLEASE INITIAL ALL ELEMENTS THAT YOU AGREE TO HAVE RELEASED

Initial if may be released	HIV test results Specify dates:
Initial if may be released	Alcohol and Drug Abuse Treatment Records Federal law prohibits 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 federal law. I can revoke this authorization in writing at any time, except to the extent that Pediatric Associates of Kingston, LLC has relied on it.
Initial if may be released	Details of mental health diagnosis and/or treatment provided by a psychiatrist, psychologist, mental health clinical nurse specialist, or licensed mental health clinician I understand that my permission may not be required to release this information for payment purposes.
Initial if may be released	Confidential communications with a licensed social worker
Initial if may be released	Information related to a sexually transmitted disease
Initial if may be released	Information related to diagnosis or treatment of hepatitis
Initial if may be released	Information related to diagnosis or treatment of pregnancy
Initial if may be released	Information related to spouse abuse and/or child abuse or neglect
Initial if may be released	Information concerning family violence and/or domestic violence victims' counseling
Initial if may be released	Information concerning rape and/or sexual assault counseling

I hereby authorize PAK PEDIATRICS to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that PAK PEDIATRICS cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at PAK PEDIATRICS may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date, unless otherwise specified. I can, however, cancel this authorization in writing at any time, except to the extent that PAK PEDIATRICS has relied upon it. For example, if I cancel it after PAK PEDIATRICS has sent the requested records, PAK PEDIATRICS will not retrieve those records. Instructions for canceling this authorization are included in the PAK PEDIATRICS Notice of Privacy Practices.

I understand that PAK PEDIATRICS will continue to provide care, even if I do not authorize this release.

I understand that PAK PEDIATRICS charges a fee for copying medical records, as identified above, and agree to pay this fee at the time of my request.

_____ Date _____
Patient Signature

_____ Date _____ Relationship to Patient _____
Parent/Guardian Signature