INDIVIDUAL PATIENT RELEASE FORM

Cape Cod Pediatrics
Authorization to use or disclose protected health information

I hereby authorize use or disclosure of the names individual's health information as described below:

Patient name: **date of birth:**

Address (street, city, state, zip code) **Phone number:**

The following individual or organization is authorized to make the disclosure:

- ❑ Cape Cod Pediatrics
- ❑ Other (please specify)_____

The information may be disclosed to and used by the following individual or organization:

- ❑ Schools/Daycare
- ❑ Camps
- ❑ Other (ie:pop warner, scouts, after school activities) _____

The following information may be disclosed:

- ❑ Immunization records
- ❑ Physician notes
- ❑ Lab results
- ❑ X-ray reports, MRI scans
- ❑ Complete record
- ❑ **Sensitive Information:**
- ❑ **To the extent applicable I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I DO NOT PERMIT information of this type, if it exists, to be released. I understand that if I do not check the box, Cape Cod Pediatrics will release such information about me if it exists;**
- ❑ **__HIV/AIDS __Sexually transmitted diseases __ Mental Health __Genetic information __Treatment for drugs/Alcohol**
- ❑ Other _____

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the study may be denied.
- I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire 12 months from date of signature.

Signature of patient or legal representative

_____ **Date**_____

Relationship to Patient

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