

SOMERSET PEDIATRIC GROUP, P.A.

Authorization to Release Medical Information

Patient's Name: _____ DOB: _____

Address: _____

1. I authorize the use or disclosure of the above named individual's health information, as described below.
2. The following individual or organizations are authorized to make the disclosure: Somerset Pediatric Group.
3. The information may be disclosed to, and used by, the following individuals or organizations:

Name(s): _____

Address: _____

For the following purpose(s): _____

4. The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose(s) and may include the following items (unless crossed out by me).

Drug and Alcohol abuse information.

Information regarding Human Immunodeficiency Virus (HIV), including laboratory results.

Diagnosis of AIDS or ARC, if applicable.

History and Physical examination.

Consultations.

Genetic testing and counseling, if applicable.

Diagnostic testing, excluding HIV testing.

Discharge summary.

Psychosocial history.

Treatment recommendations.

Other(specify): _____

5. This authorization may be revoked by me at any time except to the extent that Somerset Pediatric Group has already acted in reliance on this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to the Chief Administrative Officer, 3322 Route 22 West, Building 10, Suite 1002, Branchburg, NJ 08876. If not revoked by me, this consent will terminate on: _____.
6. I have a right to inspect the information to be disclosed.
7. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
8. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by this rule.

Signature of Patient/Legal Representative: _____ Relationship _____

Signature of Witness: _____

Date: _____

Updated: 4/28/06