PEDIATRIC ASSOCIATES OF DURANGO

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Information:

Name_____Date of Birth_____/_____/_____

Previous Name_____Patient's Phone#_____

Information Sent to:
I request and authorize **Pakhi Chaudhuri MD, Pediatric Associates of Durango** to release health care information about the patient named above to:

Name: _____ Institutional Affiliation: _____

Address/City/State/Zip Code: _____ Phone #:_____

Telephone Number (970)-259-7337 Fax Number (970) 259-7366

Information to be released:

_____Entire PA Record_____Immunization Records Other (please specify)_____

Purpose for which disclosure is being made:

_____Attorney_____Insurance_____Doctor_____Personal_____School

Patient Authorization:
I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorder/mental health, or drug and/ or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

*EXCLUDE the following information from the records released (please initial):
_____Drug/Alcohol abuse/treatment & diagnosis _____Sexually transmitted disease
_____HIV/AIDS diagnosis/treatment/testing _____Mental Illness or Psychiatric Treatment

My Rights:
I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment).
However, I do have to sign an authorization form:

- To take part in a research study, or
- To receive health care when the purpose is to create health information for a third party

I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to our patients. I understand once Pediatric Associates of Durango discloses health care information, the person or organization that receives it may re-disclose it, at which it may no longer be protected under Privacy Laws.

Signature of patient or patient's legally authorized representative Date

Relationship or status if signed by anyone other that patient (parent, legal, guardian, personal representative, etc.)

Patient Signature (if over 13 years of age)
This authorization expires 90 days after the date it is signed.