

ASSOCIATES, P.A.

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Signature of Witness:

Donna A. Page, M.D.

Susan R. Cohen, M.D.

Leigh M. Dodson, M.D.

Calvin O. Tomkins, M.D.

Peter D. Leimena, M.D.

Eleanor A. Martin, M.D.

_Date: _

Authorization for Disclosure of Health Information (Autorización para utilizar o divulgar su Información de Salud) I hereby authorize the disclosure of the following information from the health records of:
 (Autorizo la divulgación de la siguiente información de los registros de salud de):

			DOB/(Fecha de nacimiento); Phone #:			
2. This information	n will be disclosed					
To:			From: Asheville Pediatric Associates			
Name of Office/Guardian			2 Medical Park Drive			
Address			Suite 1000			
City	State /	Zip		Asheville, NC	28803	
Phone #		x #	Phone	:828-254-5326	1	Fax:828-251-5954
Consultation X-ray Repor Immunizatio I understand that the Acquired Immunizatio Human Immunizatio Behavioral heater Treatment for	nysical Examination Reports ts ns this will include information will include information with the service psyconomic alcohol and/or constant in the service psyconomic alcohol and serv	us (HIV) infection chiatric care lrug abuse ay be revoked in w	Problem Laborate Other (P o (check if applie	lease Specify):_cable):	xtent th	
condition.				·		onsibility or liability for
		to the extent indica			•	
Parent/Guardian	Name:					
Signature:						Date:
Relationship to P	atient:					