



ASHEVILLE

Pediatric

ASSOCIATES, P.A.

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Authorization for Disclosure of Health Information
(Autorización para utilizar o divulgar su Información de Salud)

1. 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):

Patient's Name/(Nombre del Paciente): \_\_\_\_\_ DOB/(Fecha de nacimiento): \_\_\_\_\_

Address/(Dirección): \_\_\_\_\_ Phone #: \_\_\_\_\_

Covering the period(s) of health care from \_\_\_\_\_ to \_\_\_\_\_

2. This information will be disclosed

To: Asheville Pediatric Associates

2 Medical Park Drive

Suite 1000

Asheville, NC 28803

Phone: 828-254-5326 / Fax: 828-251-5954

From:

Name of Office

Address

City

State

Zip

Phone #

Fax #

For the purpose of \_\_\_\_\_

3. Information to be disclosed:

\_\_\_ History & Physical Examination/ Well-Child Visits

\_\_\_ Consultation Reports

\_\_\_ X-ray Reports

\_\_\_ Immunizations

\_\_\_ Discharge Summary/ Specialists Notes

\_\_\_ Problem & Medicine Lists

\_\_\_ Laboratory Tests

\_\_\_ Other (Please Specify): \_\_\_\_\_

I understand that this will include information relating to (check if applicable):

\_\_\_ Acquired Immunodeficiency Syndrome (AIDS)

\_\_\_ Human Immunodeficiency Virus (HIV) infection

\_\_\_ Behavioral health service/psychiatric care

\_\_\_ Treatment for alcohol and/or drug abuse

4. I understand this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition.

5. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Parent/Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*PLEASE SEE OTHER SIDE FOR MEDICAL RECORDS FEES\*\*\*\*