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Authorization for Disclosure of Health Information
(Autorizaciön para utilizar o divulgar su Informaci6n de Salud)

I hereby authorize the disclosure of the following information from the health records of:
(Autorizo la divulgacién de la siguiente informaciön de los registros de salud de):
Patient's Name(Nombre del Paciente):____________________ DOB(Fecha de nacimiento):________
Address (Direccion):___________________________________ Phone #: _______________________
____
Covering the period(s) of health care from _____________ to ______________________

To: Asheville Pediatric Associates
2 Medical Park Drive Suite 1000
Asheville, NC 28803
Phone:828-254-5326 / Fax: 828-251-5954

From:
Office Name ______________________
Address__________________________
____
City ___________State_____Zip______
Phone__________Fax______________

For the purpose of ____

Information to be disclosed:

___ Most Recent History & Physical Examination

___ Problem List

___ Medication List

___Growth Charts

___ Labs

___ Immunizations

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

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.

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:________