Premier Pediatrics, Inc.
John B. Bennet II, M.D.
Colleen Hughes, MSN, RN, CPNP

Westlake
26040 Detroit Road, Suite 7
Westlake, OH 44145
Fax: 440-871-3098
440-871-1717

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient: _____ Date of Birth: _____ /_____ /_____

Current Address: _____ Telephone #: _____

City: _____ State: _____ Zip: _____

I hereby authorize _____ to release the health information indicated below that is contained in my, or my child's, patient records. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient psychotherapy notes (defined as notes that document private, joint, group or family counseling sessions that are separated from the rest of a patient's medical record). Release of psychotherapy notes requires a separate authorization.

Mail to: Premier Pediatrics, Inc. OR Fax: 440-871-3098

Street: 26040 Detroit Road, Suite 7

City: Westlake State: OH ZIP: 44145

Reason for Disclosure:
_____
(Reason for disclosure must be completed prior to processing.)

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to _____. Unless otherwise revoked, this authorization will expire one year from the date of authorization written below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, and I understand that my, or my child's, health care will not be affected by whether or not I sign this authorization. I can revoke this authorization at any time, except to the extent that action has been taken. Once my, or my child's, health care information is released, redisclosure of my, or my child's, health care information by the recipient may no longer be protected by law.

If I have questions about disclosure of my, or my child's, health information or this authorization, I can contact:

_____.

_____ _____ /_____ /_____
*Signature of Patient/Patient's Personal Representative** *Date Signed*

_____
Printed Name

_____
Relationship, if not Patient

 ** If not the patient's signature or a parent signing for a patient under 18 years old, a copy of a legal document verifying the patient's personal representative must be attached.*