NEW HORIZON PEDIATRICS

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: ______________________ **SS#:** ______________

Street Address: ______________________

City: ______________ **State:** ______________ **Zip:** ______

Date of Birth: ______________ **Telephone:** ______________

- I agree to the release of health records and/or information as stated below.
- I understand that I may refuse to sign this form and that not signing this form will not affect my services, treatment or payment for services; unless the services are only to create a record for someone else, such as physical exam or drug testing for an employer or insurance company; or if the services are research-related and your signature is required so that your results can be used for the research.
- I understand that I may see and copy the information described in this form if I ask for it.
- Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding **alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV,) or mental health treatment or counseling.**

I authorize New Horizon Pediatrics to release information to: ______________________

I authorize New Horizon Pediatrics to obtain information from: ______________________

The purpose or need for the disclosure: ☐ At the request of the individual ☐ Other (Specify:) ______________

Information to be disclosed (*admission/discharge dates*:)

☐ Discharge Summary ☐ Emergency Room ☐ Face Sheet ☐ History/Physical
☐ Operative Report ☐ X-Ray Report ☒ Other MEDICAL RECORDS

I understand that this authorization is voluntary and that I have the right to revoke it at any time prior to its expiration date by written notification to ______________. This revocation will not have any effect on the information released pursuant to this Authorization before the revocation. I understand that the information released may be subject to redisclosure by any recipient and no longer protected by federal privacy laws.

Expiration Date or Event: ______________________

Information to be released: ☐ Verbally ☒ Photocopy ☐ Faxed ☐ Other ______________

Signature ______________ Date ______ Parent/Guardian/Representative Signature ______________ Date ______

Witness ______________ Date ______ Legal Authority of Representative ______________

Released by ______________________ Date ______________ Correspondence
Copy of Auth. provided to Individual by: ______________ Date ______________ Section

SEND TO:

New Horizon Pediatrics
11911 N. Meridian St.
Suite 180
Carmel, IN 46032