AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the health care provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____

Physician/Healthcare Facility

to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including X-rays, correspondence and/or medical records by means of mail, fax, or other electronic methods.

To: **West End Pediatrics**
2440 M Street, NW #422
Washington, DC 20037

The medical information/records will be used for the following pupose:_____

This authorization is:

☐ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

☐ Limited to the following medical information: _____

Duration: This authorization shall be effective immediately and remain in effect until _____

Restrictions:

Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature of Patient *Or legal/personal representative*	Relationship to Patient
Patient's Name (PRINT)	Date
Patient's Social Security Number	Patient's Date of Birth
Witness Name	Witness Signature