Pediatrics of Steamboat Springs

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RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I,/We _____, hereby authorize Pediatrics of Steamboat Springs to release information/ discuss Protected Health Information with/to the following provider/ school:
Name: _____
Address: _____
Ph#:_____Fx#_____ Email: _____

The disclosure of information is for the purpose of:
____ Treatment Care and Coordination
____ Other (indicate the specific reason) _____

Information to be disclosed:
All of my health information that the provider has in his/her possession, **including information relating to drug or alcohol abuse, psychiatric history, HIV testing, sexually transmitted diseases, contraception and pregnancy.** (Cross out what you DO NOT want included.)

I/We understand that authorization shall remain valid from the date of my signature below and for 12 months thereafter (or sooner if specified) ending on:_____ (Date Authorization Expires)

I/We have been informed that I/we may revoke this authorization by written or oral communication with Pediatrics of Steamboat Springs at any time.

IF PATIENTS ARE 13YRS OR OLDER, THEY MUST SIGN FOR THE FOLLOWING:
I specifically consent to the release of information relating to:
- Substance abuse (including drug/alcohol abuse)
- Mental health (including psychotherapy notes)
- Sexually transmitted diseases and HIV related information
- Contraception and pregnancy counseling/evaluation

Signature: _____ **Name:**_____

_____ _____
Signature of Patient or Parent/Guardian Date of Authorization

_____
Printed Name