Authorization to Share Information with Family and Friends

On behalf of _____, born_____,I authorize Piedmont Pediatrics AND the persons listed below to have a access to any and all of the information that Piedmont Pediatrics has in my medical record.

Name	Relationship	Phone Number

As the person signing this authorization, I understand that I am giving my permission for the disclosure of confidential health care records which includes information such as visit summaries, immunization records, vital history, scheduling history and prescription history and requests, and any letters or forms received or completed on my behalf. Additionally, if applicable, PSYCHIATRIC, DRUG/ALCOHOL OR HIV TESTING/TREATMENT records and other information contained in the medical record, unless otherwise indicated under my special instructions written below, will also be accessible to the individuals listed above.

I understand that I have the right to revoke this authorization. I understand that the revocation will not apply to the information that has already been released in response to this authorization. I also understand that my revocation may not be effective if I lack the capacity to sign the revocation, if a licensed provider determines that revocation is reasonably likely to cause serious harm to me or other person, or when the revocation is not permitted by law.

Special Instructions/Requests:

_____

_____

_____

This authorization is valid for the information/purpose(s) indicated above until revoked in writing unless otherwise requested in the Special Request section of this authorization.

X_____

Signature of Patient or Legal Representative Date

If signing by Legal Representative, indicate relationship to patient: _____