BEAUFORT PEDIATRICS, P.A.

Pediatric and Adolescent Medicine
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hearby authorize (name of provider)_____Phone_____
to disclose the following information from the health records of: Fax _____

Patients Name:_____ DOB_____
Address:_____ Telephone:_____
City _____State:_____ Zip:_____
Period of Health Coverage: _____ TO _____

2. Information to be disclosed:

A.	Complete Health Record	F.	Discharge Summary
B.	History and Physical Exam	G.	Progress Notes
C.	Consultation Reports	H.	Laboratory Results
D.	Procedure Reports	I.	X-Ray

E. Patient/Parent/Legal Guardian/Responsible Party's demographic information
Check all that apply:
_____Name _____Address _____State/Zip Code _____Social Security Number
_____ Phone _____DOB _____ Gender _____Race _____Other

I understand this will include information relating to:

- Behavior Health Service/Psychiatric Care
- Acquired Immunodeficiency Syndrome Human (AIDS/HIV)
- Treatment for Alcohol and Drug Abuse

3. This information is to be disclosed to:
Name_____
Address_____
City_____State_____Zip_____
Reason for Disclosure_____

4. I understand that this authorization may be revoked in writing at any time unless action has been taken in reliance of this authorization. This authorization expires on _____ unless otherwise revoked.

5. Beaufort Pediatrics, PA, the Physicians, Staff and officers are hereby released from any legal responsibility or liability for disclosure of the information as indicated in this authorization. I fully understand and accept the terms of this authorization.

_____ _____
Signature of Parent/ Legal Guardian Date

_____ _____
Signature of Witness Date