George Skarpathiotis, M.D., S.C.

Patient Name _____

Address _____

Phone Number _____

Date of Birth _____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above named person be forwarded:

FROM: Person/Institution _____

Address: _____

City: _____ State: _____ Zip: _____

TO: Person/Institution _____

Address _____

City: _____ State: _____ Zip: _____

Purpose or need for information: _____

Disclosure will include: (check all that apply)

____ Immunization Record ____ School Physical Form ____ Progress Notes

____ Laboratory Test Results ____ X-Ray/Radiology Report ____ Other _____

Records for the period (dates) from _____ to _____

I understand that the information to be released may include: (initial all that apply)

____ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse

____ Records of HTL-VIII or HIV testing (AIDS test) result, diagnosis and/or treatment

____ Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans and/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this office except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but **will expire in 1 year after signing.** I have a right to inspect a copy of the health information to be released and if I do not sign this authorization, the institution named above will not release my health information. The person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and not disclosed to others.

_____ _____ _____

Signature of Parent/Legal Guardian/Personal Representative Relationship to Patient Date

_____

Please Print Name

_____

Witness

REDISCLOSURE: Notice is hereby given to the parent or legal representative signing this Authorization and the recipient named above that this health information disclosed under this Authorization may be re-disclosed by the recipient to others. Federal law, rules and regulations prohibit the recipient from disclosing any health information that may be included regarding treatment for drug/alcohol abuse.