Mejia Pediatrics LLC

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

PATI ENT NAME:

DATE OF BIRTH:

DATE:

I hereby authorize the Medical Records Staff of Mejia Pediatrics LLC to request my child's medical records from the following facility for the purpose of medical treatment:

FACILITY N A M E,

ADDRESS:

FA X NUMBER:

I understand that the information to be disclosed includes my identity, diagnoses and treatment, including alcohol, d rugs, genetic testing , behavioral or mental health services, reproductive rights, sexually transmitted & infectious diseases, AIDS and HIV information as applicable.

It is my intent that the use of the information furnished is prohibited for any other purpose than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that this revocation will not apply to the extent that Mejia Pediatrics LLC has already taken action in reliance to this authorization. This authorization will a automatically expire in 90 days from the date of my signature, unless I otherwise specify that this authorization terminate on the following date_____ .

I understand that authorizing the disclosure if this health information is voluntary. I can refuse to sign this authorization . I need not to sign t is form in order to assure treatment, payment, enrollment or eligibility for benefits . I understand I may inspect or obtain a copy of the information to be use or disclosed as provided i n CFR 164 .524 . If I have questions about disclosure of my health i nformation, I can contact Mejia Pediatrics LLC at 908-436-1002 .

PARENT/GUARDIAN SIGANTURE :_____

4 3 3 North Broad St. Elizabeth • New Jersey 07208 •
Phone (908) 43 6- 1002 •
Fa x . (908) 43 6- 1109