Authorization to Release Protected Health Information

Under the requirements of HIPAA, children age 14 and older must consent to allow parents or other family members to receive information relating to their medical information. This includes test results and financial information. We are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to anyone other than you then you must complete this form.

Patient or authorized representatives have the right to revoke this consent, in writing, except where we have already made the disclosures in reliance on your prior consent.

I authorize ACTON ROAD PEDIATRICS to release my medical records and any information requested to the following individuals.

1. **_____ Relation to Patient: _____**
2. **_____ Relation to Patient: _____**
3. **_____ Relation to Patient: _____**
4. **_____ Relation to Patient: _____**

Authorization Regarding Messages
(please check all that apply)

___ I authorize you to leave a detailed message on my home or cell number regarding appointments.

___ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

___ I authorize you to leave a message with anyone who answers the phone.

___ Messages may only be left with _____

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature