Four Seasons Pediatrics
532 Moe Road
Clifton Park, NY 12065
Ph 518-383-2425
Fax 518-383-3255

Consent to Discuss Health Information with Others

I, the undersigned, hereby authorize **Four Seasons Pediatrics,** located at **532 Moe Road Clifton Park, NY 12065,** to release / disclose / discuss medical information with the following individuals:

Individual 1 _____

Relationship _____

Phone Number _____

Address _____

_____

Individual 2 _____ (optional)

Relationship _____

Phone Number _____

Address _____

_____

Individual 3 _____ (optional)

Relationship _____

Phone Number _____

Address _____

_____

Specific information allowed in this consent:

- ❑ Routine medical information regarding office visits, treatments and findings
- ❑ Medical insurance details, account balances, prior authorizations, referrals

- ❑ Limitations or exclusions? _____

_____

_____

- ❑ **Items below need specific authorization**. Please indicate by signature to include the following:

Alcohol/Drug Treatment signature _____ date _____

Mental Health information signature _____ date _____

HIV- related information signature _____ date _____

Duration:
This authorization will become effective immediately and shall remain in effect unless specified by dates

or defined events noted here: _____

_____

Revocation:
This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. Written revocation may be addressed to: Privacy Officer, Four Seasons Pediatrics 532, Moe Road Clifton Park, NY 12065.

Re-disclosure:
I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. If this authorization indicates by signature HIV, Drug/ Alcohol treatment, mental health information is being disclosed the recipient is prohibited from redisclosing such information without authorization unless permitted to do so under federal and state law.

A copy of this authorization is as valid as the original. I have the right to receive a copy of this authorization.

Print Name _____**DOB**_____

Signature _____

Best contact phone # _____

Email address _____

Date _____