Greenwich Pediatric Associates

Authorization to Release Information to Family Members

Many of our adult patients allow family members such as their parents or grandparents to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A., 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 any family members you must sign this form.

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

____I authorize Greenwich Pediatric Associates to release my records and any information requested to the following individuals.
____I authorize Greenwich Pediatric Associated to release only my immunization records to the following individuals.

1. ___________________________________ **Relation to Patient:**____________________

2. ___________________________________ **Relation to Patient:**____________________

3. ___________________________________ **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 message with anyone who answers the phone

____ Messages may only be left with ____

_____________________________ **Patient Name (PLEASE PRINT)**

______________ **Date of Birth**

_____________________________ **Patient Signature**

______________ **Date**

A separate release should be filled out if the patient would like us to share information on mental health, substance use, or reproductive health. This information will otherwise not be shared.

Greenwich Pediatric Associates
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