176 N. Village Ave., Suite 1D
Rockville Centre, NY 11570
(516) 766-4094 (p)
(516) 766-4092 (f)
www.abcpeds.com
reception@abcpeds.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

I hereby request and authorize _____
to release healthcare information of the patient named above to:

ABC Pediatrics, P.C.
176 North Village Avenue, Suite 1D
Rockville Centre, NY 11570
516-766-4094 (phone)
516-766-4092 (fax)

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition or dates:

_____

□ All healthcare information

□ Other _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□ Yes □ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ _____
Signature of Patient or Legal Representative Date

THIS AUTHORIZATION REMAINS IN EFFECT UNTIL RESCINDED.