Windhaven Adolescent & Sports Medicine

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION from:
Windhaven Adolescent & Sports Medicine

Patient's name_____DOB____/____/____
Phone contact_____email contact_____

I_____(patient or parent/gaurdian if patient <18 yrs) hereby authorize Dr. Scalfano/Windhaven Adolescent Medicine to release Medical information on the above named patient to:

_____(NAME)
_____(ADDRESS)
_____(PHONE)
_____(FAX)
_____(SECURE E-MAIL)
(healthcare facility or doctor who needs the information/records FROM Dr.Scalfano)

My authorization is confined to the following information (please send only):

_statement of charges/payments
_hospital records for the following visit dates_____
_immunization records
_imaging/radiology results
_growth charts
_visit notes
_lab results
_all records

This authorization is given freely with the understanding that: 1. Any and all records, whether written, oral, or electronic are confidential and cannot be disclosed without prior written consent, except a otherwise provided by law. 2. A scanned copy or fax of this form is as valid as the original. 3. I may revoke this authorization at any time, except where the information has already been released. This authorization is valid for a 1 year year period from the date signed or sooner if noted below. The revocation must be in writing. 4. Windhaven Adolescent Medicine, it's employees, officers, physicians are hereby released from any legal responsibility or liability for disclosure for the above information to the extent indicated and authorized herein. 5. Treatment. Payment, enrollment, or eligibility may not be conditioned upon obtaining this authorization. 6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____Patient's name (guardian if <18 yrs)

_____Signature _____Date