DARIEN PEDIATRIC ASSOCIATES, LLC
106 Noroton Avenue
Darien, CT 06820

I, _____, direct my health care and medical services providers to **disclose** and release my protected health information described below to:

Name:_____

_____

Contact information:_____

Health information to be disclosed upon the request of the person named above:
(check either A or B)

□**A.** **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment and billing, for all conditions) **OR**

□**B.** **Disclose** my health record, as above, **BUT do not disclose** the following:
(check as appropriate)
□Mental health records
□Communicable diseases (including HIV and AIDS)
□Alcohol/drug abuse treatment
□Other (please specify) _____

□May we phone, or email or send a text to confirm appointments? □yes □no
□May we leave a message on your answering machine at home or on your cell? □yes □no

Form of Disclosure:
□Hard Copy
□Conversation

This authorization shall be effective until (check one):
□All past, present and future periods OR
□Date or event:_____
Unless I revoke it. (**NOTE**: You may revoke this authorization in writing at any time by notifying your health care provider, preferably in writing.)

_____ _____
Name of Individual giving this authorization Date of birth

_____ _____
Signature of Individual giving this authorization Date

2018