Amherst Pediatrics, LLP
31 A Hall Dr. Suite 2 * Amherst, MA 01002 * Phone 413-253-3773 * Fax 413-256-0215

# Authorization To Share Protected Health Information

Patient Name: __________________________ Date of Birth___/___/___

I authorize Amherst Pediatrics, LLP to share my protected health information with:

______________________________ _________________________________

Name of Parent/Parents Address

Phone # ______________________ Fax # ________________________

Information to be released:

_____ Complete medical records; or

______ Current Diagnosis of ___________________________________

If applicable, I authorize release of any information regarding:

Substance Use ___________________ STD/HIV Information ___________________
Signature Signature

Sexual Activity_________________
Signature

This information will not be released without specific permission.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Amherst Pediatrics, LLP.

This authorization will be valid for one year from the signature date or until ___/___/___.

___________________________________________ ___/___/___
Patient signature (Date)

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