

# AMHERST PEDIATRIC ASSOCIATES

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

The undersigned hereby authorizes the disclosure of information from Amherst Pediatrics:

TO: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Purpose or need for disclosure: \_\_\_\_\_

Covering records for the period from \_\_\_\_\_ to \_\_\_\_\_.

The parent/legal guardian must sign this authorization form for any child under the age of 18, or any child who is physically unable to sign. It is also understood that the above described information may include dates, history of illness, social history, diagnostic and therapeutic information, including psychiatric care and any treatment for alcohol and drug abuse. Any exception to the release of information is as follows:

\_\_\_\_\_

\_\_\_\_\_

Witness \_\_\_\_\_ Signed \_\_\_\_\_

Date \_\_\_\_\_ Date \_\_\_\_\_

**There is a fee of \$0.50 per page which will be billed to the responsible party.**