BASS RIVER PEDIATRIC ASSOCIATES

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PATIENTS AGE 18 OR OLDER
CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

Patients Name: _____ D.O.B._____
I have agreed to let certain individuals participate in discussions and decisions related to my medical care.
Therefore, I hereby give my permission for **BASS RIVER PEDIATRICS** and his/her staff to disclose my personal medical information to the following individual(s):
Name: _____Relationship to Patient: _____
Phone# _____

Conditions for Disclosure (Check the item(s) that apply):

☐ Bass River Pediatrics may disclose my medical information to the individual(s) above when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

Please note:
Bass River Pediatrics will not disclose confidential information without a specific release.
See release below.
I authorize the release of information relating to:
☐ Alcohol / Drug Abuse Evaluation/Treatment
☐ HIV / AIDs / STD Evaluation/Treatment
☐ Psychiatric / Mental Health Evaluation/Treatment
☐ Prescription Medicine Refills

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____

Date of Signature: _____