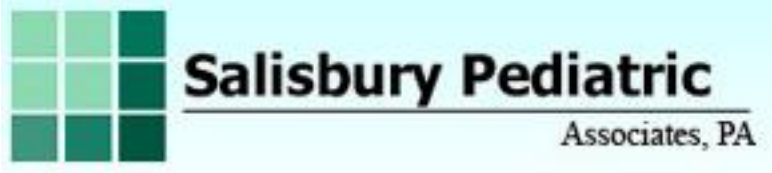

Authorization for Release of Information

Name of Patient:_____DOB:_____

Salisbury Pediatric Associates, P.A. is authorized to allow the following people to bring my child to appointments, consent for treatment, and release protected health information:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Description of information to be released:

____All information
____Financial information
____Medical information
____Lab results
____Test results
____Other information as described:_____

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document, by sending a written notification to the Privacy Officer of Salisbury Pediatric Associates, P.A. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and is not protected by federal or state law at that point.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____ **Date:**_____
Signature of Patient or Personal Representative
(Attach documentation of Personal Representative's Authority)