JACKSON PEDIATRIC ASSOCIATES
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. I, _____, hereby give my consent to _____ to release to:
   Patient/Guardian Physician/Facility
   Name/Facility_____
   Address_____

2. Information from the medical record of:

   Patient Name_____
   Address_____
   Birth date and/or Social Security No._____
   Phone_____
   Date (s) of Treatment_____
   Medical Record Number (if known) _____

3. Information to be released:

   _____ authorizes _____to release his/her entire medical
   Patient /Guardian Physician/Facility
   record excluding information to HIV or AIDS and the following (if applicable) _____

   _____ authorizes _____to release his/her medical
   Patient Physician/Facility
   information related to HIV or AIDS.

4. Purpose of Release:

   ____Medical Care _____Personal Information
   ____Insurance _____Other _____

5. This authorization shall be effective following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the above listed Physician or Facility. A photocopy of this authorization shall constitute a valid authorization.

6. If deemed necessary by _____,I authorize this information to be sent via facsimile
   Physician/Facility
   (fax) transmission.

7. The Physician, Facility, and their employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

   Patient or Representative_____ Date_____
   Relationship to Patient (if applicable)_____

NOTICE TO RECIPIENT

The recipient of the enclosed information is not authorized to use this patient's medical records for any purpose other than for that stated above or to disclose any information from the record to any other person or facility without specific written authorization from the patient to do so.