Ettienne's Premier Pediatric Care, LLC.

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

Patient's Name: _____

Birth Date: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Dr. Ettienne and her staff to disclose my personal medical information to the following individual(s):

Name: _____

Relationship to Patient: _____ Phone# _____

Name: _____

Relationship to Patient: _____ Phone# _____

Authorization:

□ I authorize *Ettienne's Premier Pediatric Care LLC.,* to release the information marked above.

□ I understand that when the health information is released, the information could be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.

□ I understand that my health care and payment for health care will not be affected if I do not sign this form.

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

□ *Ettienne's Premier Pediatric Care LLC.,* 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: *Ettienne's Premier Pediatric Care LLC.,* 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
□ Pregnancy Evaluation/Treatment

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

Patient Signature: _____ Date of Signature: _____