



Pediatric Epilepsy & Neurology Specialists

Authorization to Receive Information for Continuation of Care

Patient Name: _____ DOB: _____

For the purpose of continuing care I, _____, authorize Pediatric Epilepsy and Neurology Specialists to receive copies of the above identified patient medical records including Medical, Psychiatric Care, Drug and Alcohol Abuse and HIV/AIDS/ARC related information.

PEDIATRIC EPILEPSY AND NEUROLOGY SPECIALISTS

1. I understand that this consent includes and authorizes access to all of the identified patient's health information. I also understand that this consent is voluntary and not required to receive services.
2. I understand that this consent is revocable upon notice. I also understand that the consent shall remain in effect until revoked in writing.
3. I understand that this consent authorizes release of psychiatric information, if present.
4. I understand that this consent authorizes release of AIDS/ARC information and/or HIV antibody testing/results, if present.

Signature of Patient/Legal Guardian

Date

Print Name

Relationship

Witness

Date

CONFIDENTIALITY NOTICE

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