Wolff Center
For Child & Adolescent Health

1530 East Airport Blvd
Pensacola, FL 32504
Phone: 850-474-4777
Fax: 850-484-2656
www.wolffcenter.com

Patients 18 years or older Authorization to Release Healthcare Information to Parent/Care Giver

Patient's Name: _____
Patient's Date of Birth: _____
Patient's Social Security #: _____

I request and authorize the Wolff Center for Child & Adolescent Health to release healthcare information of the patient named above to Parent/Care Giver:

Name of Parent/Care Giver: _____
Address: _____
City, State, Zip: _____

This request and authorization applies to:

☐ All healthcare information including Lab results, and Diagnostic Imaging.

☐ Other (please specify): _____

Yes No I authorize the release of the results of my STD, HIV/AIDS testing, Pregnancy testing, whether negative or positive, to the person(s) listed above.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Yes No I understand that test orders will be visible on my billing statements and insurance explanation of benefits, and will be visible to my authorized parent/caregiver if they are listed below as financially responsible.

Financial Responsibility/Billing Statements should be sent to (parent must be present to sign acceptance):

Name: _____ Relationship: _____

Signature of person accepting financial responsibility (if applicable):_____

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this form is voluntary. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations.

Patient Signature: _____ Date Signed: _____