University Pediatrics of Lorain

ADULT PATIENT REGISTRATION FORM

Patient Name:	DOB:	Primary Care Physician:	Date:

In the event we cannot contact you, _____/_____ please list
Patient Name DOB
below who, if anyone, we may discuss your personal information with as stated below:

_____ Relationship to patient _____

_____ Relationship to patient _____

_____ Relationship to patient _____

_____ Relationship to patient _____

I, the undersigned, authorize University Pediatrics of Lorain and its physicians and employees to release information from my medical records as deemed necessary. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, HIV test results, AIDS, AIDS-related condition, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to disclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, even, or condition_____. If I fail to specify an expiration date, even, or condition, this authorization will expire in one year.

_____
Signature of Patient:

_____
Date: