Star & Fox Pediatrics

257 Station Avenue
South Yarmouth, MA 02664
Phone: (508) 500-6622
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Patients 18 Year or Older Authorization to Release Healthcare Information

PATIENT INFORMATION	
Patient's full name and date of birth:	Patient's social security #:
Patient's phone #:	Patient's e-mail:

I request and authorize Star and Fox Pediatrics tom release healthcare information of the patient named above to parent/caregiver:		
Parent/caregiver full name:		
Street address:		
City:	State:	Zip:
Parent/caregiver phone #:		

This request and authorization applies to:

- ☐ All healthcare information including lab results and diagnostic imaging
- ☐ Other (please specify)_____

I authorize the release of the results of my STI, HIV/AIDS testing, Pregnancy testing, whether negative or positive, to the person(s) listed above.

- ☐ No
- ☐ Yes (sexually transmitted infections include herpes, human papilloma virus, genital warts, condyloma, chlamydia, syphilis, chancroid, lymphogranuloma venereum and gonorrhea)

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

- ☐ No
- ☐ Yes

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.

- ☐ No
- ☐ Yes

Financial responsibility/billing statements should be sent to:

Name: _____Relationship: _____

Patient Signature: _____Date Signed: _____