EXETER PEDIATRICS
6 HEARTHSTONE CT., STE. 201 READING, PA 19606
PHONE: 610-779-9550 FAX: 610-779-6433

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ___________________________ ________________________ ____________________
Patient's Full Name | Date of Birth | Phone Number

____ ________________________________
Address-Street, City, State, Zip | Current Insurance

Do hereby authorize**:**

_____________________________________ Name of Company/Facility/Person

______________________________________(address)

______________________________________(address)

______________________________________ (phone / fax)

To Release to:

Exeter Pediatrics
6 Hearthstone Ct., Ste. 201
Reading, Pa 19606
Phone: 610-779-9550 Fax: 610-898-5114

The following information:

- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Emergency Reports
- ☐ Lab Test Results
- ☐ EKG/ Cardiac Cath
- ☐ Other____________

____ I do _____ I do not authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care or psychological assessment, and treatment for alcohol and/or drug abuse.

Purpose of Disclosure:

- ☐ Referral to Specialist
- ☐ Insurance
- ☐ Workers Comp
- ☐ Change Of Doctor
- ☐ Legal Investigation
- ☐ Disability
- ☐ Personal
- ☐ Continuing Care

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations.

____ Date______________
Signature if individual or guardian or
Personal Representative of patient's estate.

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