Boosara Ratanawongsa, M.D
Pediatric Neurology of Lehigh Valley
961 Marcon Blvd. Suite #452
Allentown, PA 18109
(P) 610.398.9898
(F) 610.398.9899

AUTHORIZATION TO RELEASE AND DISCLOSE HEALTH INFORMATION

ALL APPROPRIATE BLANKS MUST BE COMPLETED BEFORE INFORMATION WILL BE RELEASED

PATIENT NAME:____DOB:____________

ADDRESS:____PHONE ( )______-________

Street City State Zip

I hereby authorize ____ located at

____( )_______- ________

Street City State Zip Phone

☐ Release and/or disclose information to the individual/agency/organization, identified below

☐ Obtain information from the individual/agency/organization, identified below

NAME OF INDIVIDUAL/AGENCY/ORGANIZATION, AUTHORIZED TO RECEIVE OR DISCLOSE INFORMATION

NAME: PNLV- Pediatric Neurology of Lehigh Valley

Street	City	State	Zip	Phone	Fax
961 Marcon Blvd. Suite#452	Allentown	PA	18109	610-398-9898	610-398-9899

Purpose for request:

☐Referral to Specialist ☐Insurance Related ☐Personal ☐Transfer of Care ☐Coordination of Care

☐Communication between Providers ☐Legal ☐Other__________________________________

SPECIFIC INFORMATION TO BE RELEASED

☐ Discharge/ Termination Summary
☐ Medical History and Physical
☐ Laboratory, X-rays, MRI, CT Scans and Procedures
☐ All Neurological/ Neuropsychological Records
☐ Entire Medical Record
☐ Psychological/ Psychiatric Evaluations
☐ Treatment/Care/Rehab Plan!
☐ Progress Report!
☐ Educational/ Vocational!
☐ Other (please specify) ______________

I understand the information being released is protected information and may contain behavioral or mental health services, treatment for alcohol and drug abuse, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) or drug and alcohol abuse treatment and that Federal and State laws expressly prohibit disclosure or re-disclosure without the specific written consent of the person served, legal guardian and/or parent (if a minor). Furthermore, I understand the information may be released in written, verbal, audio, or electronic format. I understand that authorization, except for action already taken, may be revoked or voided by me at anytime, by advising our office in writing. If not previously revoked or voided, this consent will expire one year from the date of signature.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment. I understand that information used or disclosed under this authorization might be re-disclosed by the recipient and no longer protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact PNLV.

____ ____________________

Parent/ Legal Guardian Signature Relationship Date

____ ____________________

Witness Signature Date

PROVIDE COPY OF COMPLETED/SIGNED FORM