Authorization for Release of Medical Records

THIS AUTHORIZATION MUST BE COMPLETED IN ITS ENTIRETY IN ORDER TO BE PROCESSED

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION / RECORDS AS DESCRIBED BELOW. I UNDERSTAND THIS AUTHORIZATION IS VOLUNTARY. I UNDERSTAND THAT IF THE ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS, AND THAT IT MAY BE RE-DISCLOSED BY THE RECIPIENT.

PATIENT / CHILD'S NAME: _____ **DATE OF BIRTH:** _____

ORGANIZATION TO PROVIDE INFORMATION:

NAME: _____

ADDRESS: _____

CITY/STATE: _____

PHONE: _____

FAX: _____

ORGANIZATION TO RECEIVE INFORMATION:

NAME: _____

ADDRESS: _____

CITY/STATE: _____

PHONE: _____

FAX: _____

I authorize the disclosure of Protected Health Information for the following reason: (please check one)

_____ **For the purpose of transferring care to a new physician**
(You will need to print this form, sign and send it to us via fax or mail)

Reason for transfer: (Optional) _____

_____ **For the purpose of transferring records to Healthy Starts Pediatrics, PC**
(You will need to print this form, sign and send it to your current physician)

I understand that I have no obligation to disclose information from my records and understand that I may revoke this authorization at any time in writing, except to the extent that action based on the consent has already been taken. I fully understand the contents of this authorization and voluntarily consent to the release of the information stated. My signature authorizes release of the information by routine mail or fax. (If signed by a parent and records are not able to be released prior to the patient's 18th birthday, a new release will need to be signed by the patient.)

X _____ _____ _____
Signature of parent / legal guardian or Patient if 18 years old | Date | Relationship to patient

***If records contain ADD or ADHD issues addressed in patient chart, or any mental health information, there must be a signature below by the patient if patient is 14 years or older.**

If this information being disclosed to the above person, organization or agency, is from records whose confidentiality may be protected by the Drug and Alcohol Act (PA Law Act 63) and / or the Mental Health Procedures Act (PA P.L. 817) and / or HIV Related Information Act (PA Law, Act 148), this information must be released.

My Signature authorizes release of above- mentioned information by routine mail or fax:

X _____ _____ _____
Signature of parent / legal guardian or Patient if 18 years old | Date | Relationship to patient