HEALTHY STARTS PEDIATRICS, PC
845 SIR THOMAS COURT, SUITE 7
HARRISBURG, PA 17109
717-652-7616
717-909-3204 (FAX)

AUTHORIZATION TO RELEASE 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:** _____

TRANSFER RECORDS FROM:	**TRANSFER RECORDS TO**:
Name: Healthy Starts Pediatrics, PC	Name: _____
Address: 845 Sir Thomas Court, Suite 7	Address: _____
City / State: Harrisburg, PA 17109	City / State: _____
Phone: 717-652-7616	Phone: _____
FAX: 717-909-3204	FAX: _____

I authorize the disclosure of Protected Health Information for the following reason:

_____ For the purpose of transferring care to a new physician
Reason: _____

_____ Other: _____

Records being requested:

_____ All Necessary Medical Records from Healthy Starts Pediatrics
(excludes mental health – see below)

_____ Include ADD/ADHD /Mental Health Records
(Requires signature at bottom of page for patients 14 and older)

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. My signature authorizes release of the information by routine mail or fax.

If not revoked earlier, this consent will remain in force for 90 days.

X _____ **Date:** _____ Relationship to Patient: _____
Signature of PARENT

X _____ Date: _____
Signature of patient if 14 years of age or older
(For release of mental health / ADHD records)