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
_____ To have records for personal use
_____ Second Opinion or Consult

Is this Authorization for specific records only? _____Yes _____ No
If so, specify what records you are requesting and the date of the service: _____
_____

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.

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

***If records contain any ADD or ADHD issues addressed in patient chart, or any mental health information, there must be a signature below.**

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