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: **Healthy Starts Pediatrics, PC**

ADDRESS: **845 Sir Thomas Court, Suite 7**

CITY/STATE: **Harrisburg, PA 17109**

PHONE: **717-652-7616**

FAX: **717-909-3204**

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

_____ Other: _____

I understand that I have no obligation to disclose information from my /my child's 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

***Records containing mental health information, ADD or ADHD records will not be released for children 14 and older unless patient's signature is also shown below:**

X _____ _____

Signature of patient if age 14 or above | Date

Records released will contain only Medical information from the last 2 years unless otherwise requested. There will be a charge for paper copies.