PATIENT AUTHORIZATION TO RELEASE PHI/MEDICAL RECORDS

Reason for request: ___________ Transfer Medical Records ___________ other

This request may include disclosure of information relating to ALCOHOL/DRUG TREATMENT, MENTAL HEALTH NFORMATION and CONFIDENTIAL HIV-RELATED INFORMATION only if Patient's / Legal Guardian's initials are included next to the desired information below.

Initial for release of: _____Alcohol/Drug Treatment ______Mental Health Information _______HIV-Related Information

Patient name (s): ______________________________ Date (s) of birth: ________________

______________________________ ________________

Patient Address: ____

Patient's Primary contact number: ___________________________________

My child/children's records are to be transferred to/from:

Physician Name: ____

Address: ____

Phone: ____Fax # ___________________________________

Reason for Transfer: ____

We will generate a summary of your medical records which includes: immunizations, problem list, allergies, medication lists, growth charts, and any labs, x-rays, and specialist reports for the past 2 years. There is a nominal fee for **paper records of $10 or we can provide a CD at no charge.** Please check here if you would like a CD____(once complete, a staff member will notify you that your disc/paper records are ready for pick up at our office. **Please provide identification at the time of records pick up. Requests will be processed once payment is received and normally takes 5-7 business days.** We accept credit card payments (over the phone is acceptable), cash or check.

Please be aware that complete medical records are available by request and will be calculated at the current processing fee set forth by the Pennsylvania Medical Society. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing (except to the extent that Pediatrics of Northeastern Pennsylvania has acted in reliance to this authorization) to Pediatrics of Northeastern Pennsylvania, HIPPA Manager at 920 Viewmont Drive, Dickson City, PA 18519

_____________________________________ _________________________

Signature of Patient/Legal Guardian Date

_____________________________________ Records will be picked up: ____Yes _____ No

Printed Name of Patient/Legal Guardian

Name/phone number of person to pick up records: ___________________________________

To be signed at pick up: Printed Name: ________________________Signature:___________________Date:______

6/9/17 jg/mc