MEDICAL RECORDS RELEASE AUTHORIZATION

Reason for request: _____

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

State regulations require signatures of all patients ages 14 to 18 to permit the release of the information below.

Initial for release of: _____Alcohol/Drug Treatment _____Mental Health Information _____HIV-Related Information

Patient name : _____ Date of birth: _____

Patient Address: _____

Patient's Primary contact number: _____

My child's records are to be released from:

Physician Name: _____

Address: _____

Phone: _____Fax # _____

Please release to: **Pediatrics of Northeastern Pennsylvania (NEPA) – Fax: 570-558-9051**

We require a medical record summary to be created to include: growth charts, immunization, allergies, current medication list, labs, x-rays, specialist reports of last 24 months, problem list and diagnosis summary list.

Please note: that your information is used/disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing to Pediatrics of Northeastern Pennsylvania , HIPAA Manager at 920 Viewmont Drive, Dickson City, PA 18519

_____ _____

Signature of Guardian/Patient Date