Meadville Pediatrics

765 Liberty Street, Suite 111
Meadville, PA 16335
Phone: 814.336.6384
Fax : 814.724.2771

MEDICAL RECORD RELEASE AUTHORIZATION FORM

The following information is required by law before we can release the medical records of your child. (See PA Code § 5100.33.)

PATIENT NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____
CITY/STATE/ZIP: _____ PHONE: _____
I, the undersigned, hereby:

☐ Authorize **Meadville Pediatrics, PC** to release my Protected Health Information **to** the following person(s)/organization(s):

Name _____
Address _____
City/State/Zip _____
Phone _____ Fax _____

OR

☐ Authorize _____ Fax _____
to release my Protected Health Information to: **MEADVILLE PEDIATRICS, PC, ATTN: OFFICE RECORDS 765 LIBERTY STREET SUITE 111, MEADVILLE, PA 16335**

Reason for request (please check one):

☐ Transfer to another provider ☐ Legal Issues ☐ Appointment with specialist
☐ Personal Use ☐ Insurance Purposes ☐ Other _____

Documents can be released electronically if original records are stored on electronic media. If you wish to have records transferred on a CD, please check to see if your health information is available for electronic release. Fees for electronic media are listed below.

INFORMATION TO BE RELEASED:

☐ Entire Record ☐ Immunization Record Only ☐ Laboratory Results _____
☐ Other Specified Records _____

The following information will be released with your electronic visit summary: (when applicable) unless checked that you do not want it sent:
Meaningful Use

☐ **Diagnostic Tests** ☐ **Consultation Reports** ☐ **Operative Reports** ☐ **Discharge Instructions** ☐ **Radiology Reports**
☐ **Problem List** ☐ **Discharge Summary** ☐ **Pathology Reports** ☐ **Lab Tests/Results** ☐ **Vital Signs/Growth Charts**
☐ **Medication List** ☐ **Emergency Room Reports** ☐ **Nurse Notes** ☐ **Rehab Records** ☐ **Family/Social History**
☐ **Allergies** ☐ **History & Physical Exams** ☐ **Physicians Orders** ☐ **Physician Progress Notes** ☐ **Immunization Record**

***** The below records will not be disclosed. For the following to be included, indicate the specific information to be disclosed and initial below:**

	Information to be disclosed	Initials
HIV/AIDS related information		
Mental Health Records		
Drug & Alcohol Treatment Program		

Copy Fee:

1. I understand there may be a charge for copying and handling my request. There is a $5.00 fee for my records to be released on CD(compact disc) for personal use. Per Pennsylvania State guidelines, Meadville Pediatrics, PC has 30 business days to release your medical records.
2. Requests for paper copies by the patient/parent will be charged per page plus postage/shipping if mailed as follows per regulations: (DOH 46Pa.B.7598):
   a. Amount charged per page for pages 1-20 $1.51
   b. Amount charged per page for pages 21-60 $1.12
   c. Amount charged per page for pages 61-end $0.38
3. Requests for records to be transferred to another physician or health care provider will not be charged for the first request. Additional requests will be charged the above rates.

I authorize the release of copies of medical records and/or other information as noted above.
I authorize this information be released by routine mail, inter-office mail, fax, or pick up.
I understand that I may revoke this authorization at any time.. If not revoked earlier, this consent will remain in effect for thirty (30) days from the date signed below.
I understand that if the person or entity that receives the described records is not subject to federal privacy regulation or laws, the records may be re-disclosed an no longer protected by those regulations.
I understand that the healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may refuse to sign this authorization.

Date of Signature _____ Signature of Patient or Parent/Guardian (if patient is under 18) _____ Printed name of Patient or Parent/Guardian _____

☐Patient ☐ Parent or Legal Guardian ☐Power of Attorney