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Outgoing

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 _____

Reason for request (please check one):

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

INFORMATION TO BE RELEASED:

- Entire Record
- Other Specified Records _____ Dates: _____
- Immunization Record Only
- Laboratory Results _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release

A CHECK MARK IS REQUIRED to release information from a licensed mental health facility, licensed drug and alcohol facility.

- Drug/Alcohol
- Mental Health (Psychiatric)

PATIENT'S RIGHTS REGARDING THIS RELEASE OF RECORDS

- 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, Direct Message, or pick up.
- I understand that I may revoke this authorization at any time, in writing. 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 and 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 Printed name of Patient or Parent/Guardian

Relationship to patient if signer is not the patient

If you are the legal representative of the person listed above, please check the basis for your authority:

- Power of Attorney (attach copy)
- Guardianship (attach copy)
- Parent of Minor
- Other _____ specify and attach copy

Witness

Date