East Suburban Pediatrics

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth:_____

Patient Address: _____

Phone Number: _____

I hereby authorize_____
Provider Name

_____ _____
Provider Address Provider Phone

to release my medical record as indicated below:

_____ All Records
_____ Records only from (date) _____ to (date) _____
_____ Records pertaining to (describe) _____

To: **East Suburban Pediatrics**

_____ 4262 Old William Penn Highway Suite 208, Murrysville, PA 15668 **FAX 724-733-2278**

_____ 2566 Haymaker Road, Suite 106, Monroeville, PA 15146 **FAX 412-858-5132**

_____ 40 Lincoln Way, Suite 400, North Huntingdon, PA 15132 **FAX 724-863-8526**

I understand that the information in my health record may include information relating to pregnancy, sexually transmitted disease, AIDS, AIDS related syndromes or HIV testing. It may also include information about behavior or mental health services, alcohol, drugs, psychiatric and psychological information. I authorize the release or discharge of this type of information.

Disclosed information will be used for the following purpose:

_____ Transfer of care
_____ Specialist consultation
_____ Other (please specify) _____
_____ Transfer of care due to relocation or insurance change
_____ Legal

PATIENT RIGHTS AND PRIVACY

1. I understand that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by federal or state privacy regulations.
2. I understand that I have the right to revoke this authorization at any time by presenting my written revocations to the Privacy Official. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. This authorization will expire on the following date _____. If I fail to specify any expiration date this authorization will expire in ninety (90) days.
4. I understand that authorizing this disclosure of this health information is voluntary. I need not sign this form to assure healthcare for treatment.
5. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

Patient/Parent/Legal Guardian Signature _____ Date: _____

Relationship: _____

Witness: _____ Date: _____