Pediatrics South

www.pediatricssouth.com

RELEASE OF MEDICAL RECORDS TO PEDIATRICS SOUTH

I hereby authorize:

Doctor/Practice Name: _____
Address: _____
City, State, Zip: _____
Office Phone: _____Office Fax: _____

To release information from the medical records of:

Patient's Name: _____ Birthdate: _____

To the following name and address: **PEDIATRICS SOUTH**
240 MT. LEBANON BLVD.
PITTSBURGH, PA 15234
PHONE: 412.561.7541 FAX: 724.731.0261
724.731.0262

Information to be released:
_____ Immunization records only
_____Immunization records and last health review
_____All medical records
_____Other (please specify) _____

_____ _____
Signature of patient/legal guardian: **Date:**

When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. This authorization is in effect for a period of 90 days from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to privacy Officer, 240 Mt. Lebanon Blvd., Pittsburgh, PA 15234.

Scott L. Tyson, MD | **Maya Goldin-Perschbacher, MD** | **Amy A. Gosling, MD**
Janet M. Breslin, MD | **Wilmarie Garcia, MD** | **Linda E. Range, MD**
Barbara Braman, CRNP | **Rosanne Levine, CRNP** | **Marc Yester, MD**
Nila Mistry, MD | **Britta Kocak, MD** | **Susan Van Cleve, CRNP**