OFFICE USE ONLY

Patient #:_____

Date records released: _____

Released by:_____

MEDICAL RECORDS RELEASE FORM

Patient Name_____ Date of Birth_____

Address_____ City/State/Zip_____

I, the undersigned, authorize Pediatrics South to release the protected health information for the patient named above to:

Person or Facility: _____

Address: _____

City, State, Zip: _____

☐ Please mail records

☐ Please fax records – fax number: _____

☐ Email – Only available to patients registered through our Patient Portal

Dates and Type of information to release:

☐ 2 years prior from last date seen

☐ Specific Dates: _____

☐ Specific Information: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. I understand the information in my health record may include information relating to sexual history/sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. The records will be provided unless I specify that the following information should NOT be released: _____

I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. I understand that if the person or entity that receives the above information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. THERE MAY BE FEES ASSOCIATED WITH THIS REQUEST AS ALLOWED BY THE COMMONWEALTH OF PENNSYLVANIA.

Patient/Parent/Legal Guardian Signature: _____ Date: _____

Relationship to Patient: _____

(Legal Guardian may be required to attach supporting legal documentation)

Patient Signature: _____ _____ Date: _____

(If patient is a minor (between the ages 14-18) he/she must sign for Release of any Restricted Health Information)

RECORDS WILL BE COMPLETED WITHIN 30 DAYS OF RECEIPT OF COMPLETED RELEASE FORM. (60 DAYS IF RECORDS ARE OFF-SITE.)