PEDIATRICS SOUTH

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: _____

Purpose of disclosure:

_____ Transfer of Care _____ Legal _____ Moving out of area _____ Coordination of care
_____ Personal

☐ Verbal Communication

☐ Please fax records – fax number: _____ ☐ Please mail records

☐ Electronic copy (USB drive) – available for patients

Dates and Type of information to release:

☐ Immunization records and information from 2 years prior to the last date seen.

☐ 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 one year from the date of the signature or until _____ (specify date.)
I understand I have a right to receive a copy of this request.
I understand that I have the right to revoke this authorization at any time by sending a written request to Pediatrics South.
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. Pediatrics South and its staff/employees have no responsibility or liability as a result of the re-disclosure
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.)

6/2018