AUTHORIZATION TO RELEASE MEDICAL RECORDS TO:
PEDIATRICS SOUTH

Patient's Name: _____ Birthdate: _____

Patient Address: _____ City/State/Zip: _____
Home phone: _____

Medical Records to be released from:

Provider/Facility: _____
Address: _____
City, State, Zip: _____
Office Phone: _____Office Fax: _____

Medical Records to be released to: **PEDIATRICS SOUTH**
240 MT. LEBANON BLVD.
PITTSBURGH, PA 15234
PHONE: 412.561.7541 FAX: 724.731.0261
724.731.0262

Information to be disclosed: (choose one)
Verbal Communication/Coordination of Care_____
Specific Information_____
Entire Medical Record_____
*The purpose of any/all disclosure is at the request of the individual/patient.

HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: c Drug/Alcohol c HIV c Mental Health (Psychiatric)

I understand that this authorization is effective for a period of one year from the date of signature, unless otherwise specified here_____. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity I authorized above to release the information.
My treatment or payment for treatment cannot be conditioned on the signing of this authorization.

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

_____ _____
Signature of patient/legal guardian: **Date:**
(14 years of age or older may authorize release of mental health information, drug & alcohol treatment/diagnosis, HIV/AIDS diagnosis/treatment/testing, and sexually transmitted disease information.)

6/2018