PEDIATRIC HEALTHCARE ASSOCIATES
615 6TH AVENUE
ALTOONA, PA 16602
Phone (814)944-7383 Fax (814)944-7608
ALTOONAPEDIATRICS.COM

Authorization to Release Medical Record Information

PATIENT NAME **MALE/FEMALE** **DATE OF BIRTH**

I AUTHORIZE:

_____
Name of Physician, Practice, or Facility

_____
Street Address

_____
City, State, Zip Code

_____
Phone/fax number

TO RELEASE TO:

_____
Name of Physician, Practice, or Facility

_____
Street Address

_____
City, State, Zip Code

_____
Phone/fax number

Please briefly indicate why you would like these records released:

- ☐ Change of insurance
- ☐ Relocate/continuity of care
- ☐ Other (please explain)_____

INFORMATION TO BE RELEASED:

□ All records □ Immunization record only □Consultation
□Progress Note □Diagnostic Reports □Other _____

SPECIAL AUTHORIZATION: (CHECK ALL APPLICABLE)

□Alcohol and/or drug abuse record □Psychiatric records
□Sexually Transmitted Disease □HIV/AIDS information

_____ _____
PARENT/GUARDIAN SIGNATURE **PATIENT SIGNATURE (**if over 18 years**)**

I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time. The requestor may be provided with a copy of this authorization.

_____ _____
PATIENT SIGNATURE (if over 18) **DATE**

_____ _____
PARENT OR GUARDIAN SIGNATURE **DATE**

_____ _____
STAFF SIGNATURE **DATE**

_____Phone number

RECORDS FEE:

PICK UP $5.00 per patient MAILED $5.00 per patient plus postage