HIPPA AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION
PEDIATRIC HEALTHCARE ASSOCIATES

615 6TH Avenue
Altoona, PA 16602
814-944-7383 (phone)
814-944-7608 (fax)

105 Hillcrest Drive
Roaring Spring, PA 16673
814-944-7383 (phone)
814-944-7608 (fax)

PATIENT NAME____________________________ **DATE OF BIRTH**______________ male/female

I AUTHORIZE:

____
Name of practice/facility
____
Address
____
City, State, Zip
____
Phone Fax

TO RELEASE TO:

____
Name of practice/facility
____
Address
____
City, State, Zip
____
Phone Fax

INDICATE WHY YOU WOULD LIKE THESE RECORDS RELEASED

☐ change of insurance ☐ relocate/continuity of care ☐ other ____________________________

INFORMATION TO BE RELEASED

☐ All records ☐ Immunization record only ☐ Consultation ☐ Progress note
☐ Diagnostic report
☐ Other____

SPECIAL AUTHORIZATION

☐ Alcohol and/or drug use record ☐ Psychiatric records ☐ Sexually transmitted disease
☐ HIV/AIDS

__________________________ __________________________
PARENT/GUARDIAN SIGNATURE **PATIENTS SIGNATURE (18 AND OVER)**

I UNDERSTAND THAT THIS AUTHORIZATION SHALL BE VALID FOR ONE YEAR. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING TO PEDIATRIC HEALTHCARE ASSOCIATES AT ANY TIME. I UNDERSTAND THAT THE MEDICAL PROVIDER TO WHOM THIS AUTHORIZATION IS FURNISHED MAY NOT CONDITION ITS TREATMENT OF THE ABOVE-NAMED PATIENT ON WHETHER OR NOT I SIGN THE AUTHORIZATION.

______________________________ __________________
SIGNATURE OF PATIENT (18 OR OLDER) **DATE**

______________________________ __________________
SIGNATURE OF PARENT/GUARDIAN **DATE**

PATIENT/PARENT/GUARDIAN PHONE NUMBER ______________________________

IF THERE IS A CUSTODY ORDER ON FILE YOU WILL NEED TO PROVIDE US A COPY
A JOINT CUSTODY ORDER REQUIRES SIGNATURES OF ALL PARTIES