PEDIATRIC HEALTHCARE ASSOCIATES

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Pediatric Healthcare Associates

Altoona Office
615 6th Avenue, Altoona, PA 16602
Phone: +1 814-944-7383 · Fax: +1 814-944-7608

Roaring Spring Office
105 Hillcrest Drive, Roaring Spring, PA 16673
Phone: +1 814-224-2555 · Fax: +1 814-944-7608

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