PEDIATRIC HEALTHCARE ASSOCIATES

HIPAA 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 _____ 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 _____ **Patient's 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 this 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.