Pediatric Associates, PA
Medical Records Release Form

I authorize ______________________________ ____________________
Prior Health Center Phone Number

To release information to: ______________________________________
New Health Center

Initial all appropriate boxes that describe the information to be released:

_____ General Medical Record ______ Immunizations only _____ Billing Records

Initial the purpose of the release:

_____ Change of Physician ______ Change of Insurance _____ Other

This authorization will expire on:____________________
I understand this authorization will expire in six (6) months if no date is listed above.

I understand that the information in my health record may include information relating to:

- Sexually transmitted disease
- AIDS or HIV
- Behavioral, mental health or psychiatric conditions
- Drug or alcohol abuse, drug-related and/or alcohol-related treatment

I AGREE TO SUCH RELEASE OF THE ITEMS ABOVE. ____________Initial

I understand that I have the right to revoke this authorization in writing at any time. I understand that I must give my written revocation to the Health Center which is sending the records. I understand the revocation will not apply to information already released in response to the authorization.

I understand that the information used or disclosed because of this form may be subject to redisclosure by the receiving entity and may no longer be protected by the privacy regulations. I also understand that I am under no obligation to sign this authorization and my ability to obtain treatment will not depend in any way on whether I sign this authorization.

______________________________	____________	____________________
Please Print Name of Patient	Date of Birth	Social Security Number
______________________________	____________	____________________
Print Name of Requestor	Relationship	Signature
______________________________	____________	
Witness	Date	

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