

PEDIATRIC CARE OF YORK

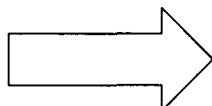
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(717) 235-6848 • Fax (717) 235-8045
rev. 05/07

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION NOT ACCEPTED UNLESS COMPLETED IN ITS ENTIRETY.

Print Patient's Full Name (s):	Date of Birth:
_____	_____
_____	_____
_____	_____

I hereby authorize PEDIATRIC CARE OF YORK To Receive Records from: To Send Records to:



Name: _____

Fill-in complete Name,
And Address

Address: _____

Please check the Reason for Release: Moving Legal Matters Transfer of Care
 Insurance change Personal Use _____
 Specialists Visit **(Other – Please Specify)**

Consent to Release My Protected Health Information (PHI) which may contain psychiatric/psychotherapy records, information related to HIV status, AIDS, sexually transmitted diseases, mental health, and drug and/or alcohol abuse.
I authorize Pediatric Care of York, P.C. or its authorized agent, to release copies of my confidential medical records, charts, notes, x-rays, and any other information relating to my or my child's care, treatment and/or general physical condition. By signing this authorization, I understand that the medical records released may contain information related to HIV status, AIDS, psychiatric/psychotherapy records, mental health, sexually transmitted diseases, and drug and/or alcohol abuse.

Date _____ Signature of Parent/Responsible Party **X** _____
Address: _____ Phone: _____

If you do not want certain protected health information released, please complete this section
You may not release my protected health information regarding testing, diagnosis, and treatment for (check all that apply):

<input type="checkbox"/> HIV (AIDS virus)	<input type="checkbox"/> Drug and/or alcohol use	<input type="checkbox"/> Other _____
<input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/> Mental health and/or psychiatric care	_____

I understand that I have no obligation whatsoever to disclose information from my record; that I may revoke this authorization at any time in writing, except to the extent that action based on this consent has been taken. I fully understand the contents of this authorization and voluntarily consent to the release of my or my child's Information.
I further understand there may be a risk the person/organization receiving my PHI could possibly disclose it without my authorization.

_____ **X** _____
(PRINT Parent/Responsible Party's Name) (Signature of Parent/Responsible Party) Relationship Date