

Chester County Pediatrics, PC

690 West Lincoln Highway, Exton, PA 19341 P:610-873-5437 F:484-713-5073

REQUEST FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____

Phone: _____

AUTHORIZES:

Name of previous healthcare provider:

Address: _____

Phone: _____ Fax: _____

TO DISCLOSE TO:

Chester County Pediatrics, PC 690 West Lincoln Highway Exton, PA 19341

Phone: 610-873-5437

Fax: 484-713-5073

DATES OF INFORMATION TO BE DISCLOSED

From: _____ to _____

INFORMATION TO BE DISCLOSED:

All medical records

Specific records:

I DO NOT WANT THE FOLLOWING DISCLOSED:

Alcohol/Drug Abuse HIV Test Results Mental Health

EXPIRATION:

This authorization is valid until the following date or for one (1) year:

PURPOSE:

Further medical care due to:

Investigation

Relocation Change of Insurance Coverage Specialist Review Legal

Other: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that this Authorization is subject to revocation/withdrawal by me at anytime to the medical record contact person at this site of care except to the extent that the action has already been taken to release this information. This Authorization shall remain valid unless revoked but WILL EXPIRE IN 1 YEAR after signing. I have a right to inspect a copy of the health information to be released and if I do not sign the Authorization, the institution named above will not release my health information. The above person/institution will refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ Signature of Patient

_____ Signature of Parent/Legal Guardian

REDISCLASURE:

_____ Date

_____ Relationship to Patient

Notice is hereby given to the patient or legal Representative signing the Authorization that Chester County Pediatrics, PC cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re disclosure of any health information regarding drug and or alcohol abuse, HIV or mental health treatment.