Beittel-Becker
PEDIATRIC ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____

Date of Birth: _____ SS #: _____

- **I authorize the use or disclosure of the above-named individual's health information as described below**
- **The type of information to be used or disclosed is as follows: (check the appropriate boxes and include other information where indicated)**

The information identified below may be used by or disclosed to the following doctor, individual, or organization(s):

Release From: _____ **Release To:** _____

Address: _____ **Address:** _____

Date(s) of Service: ☐ **Include all dates** **Other:** _____

☐ ENTIRE RECORD INCLUDING VACCINATION RECORD

☐ Demographic information only including appointment time and dates
☐ H&P
☐Consults
☐ Human Immunodeficiency Virus (HIV) Information
☐ Lab Results
☐ OTHER: please specify _____
☐ Progress Notes
☐ Medication List
☐ Behavioral Health Information
☐ Substance Abuse Information

- I understand that if my authorization includes Behavioral Health, substance abuse or HIV information, it may include (i) information concerning whether an individual has been the subject of an human immunodeficiency virus (HIV) - related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contact (Section 7100.133); (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (Pennsylvania Drug and alcohol abuse control act of 1972 - act 148 section 7(e); (iii) behavioral health information services. (Mental Health Procedures act 1976, section 5100.3-39).
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless I specify differently, this authorization will remain in effect till I revoke it, or I transfer from the practice
- I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of Patient or Patient's Legal Guardian **Printed Name of Patient or Legal Guardian**

_____ _____

Relationship to Patient **Date**

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