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Authorization to Disclose Protected Health Information

IF YOU ARE TRANSFERRING RECORDS FROM ANOTHER FACILITY TO CONCORD PEDIATRICS, PA, PLEASE FAX/SEND THIS FORM TO THE PRACTICE YOU ARE LEAVING

_____ _____

Patient's Full Name Date of Birth

I authorize:_____ to:

___ **Send/Disclose Information to: Concord Pediatrics, PA**

For the following purposes:

__Provider Transfer __Other (specify):_____

Type of information requested:

___Abstract (includes any available documents below Other health information

Or check only those documents needed): __Assessments __Nurses' Notes

__Progress Notes __Emergency Dept Notes __Itemized Bill

__History & Physical __Consultation __Other_____

Dates of care to be released:_____to_____

I UNDERSTAND THAT:

-Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.

_Once I authorize the disclosure of my health information, it is no longer protected information and re-disclosure by the recipient is legally permitted.

The following types of information WILL BE INCLUDED UNLESS INDICATED BY YOU INITIALING BELOW:

Drug and/or alcohol treatment Initials:___ Psychiatric Initials:___

Sexually transmitted disease Initials:___ Genetic Treatment Initials:___

HIV (AIDS) testing/treatment Initials:___

This authorization expires six months from the date of signature or on:_____

_____ _____ _____

Signature of patient or legal representative/guardian Authority or relationship of representative Date