HIPAA COMPLIANT AUTHORIZATION FOR RELEASE/ACCESS OF MEDICAL INFORMATION TO A THIRD PARTY

The medical records cannot be released until this form is completed and signed by the patient (if at least 18 years old) or parent or legal guardian (if under 18 years old). You must complete this form thoroughly.

PLEASE PRINT

Step 1: Patient Name: _____ Date of Birth: _____

Step 2: I hereby authorize Chester County Pediatrics to receive my health information FROM:

Name of Authorized Person/Entity_____

Address: _____

Phone : _____ Fax: _____

Step 3: I am authorizing access to the following areas of information:

- ●Immunizations
- ●Medication List
- ●Growth Chart
- ●All Chart Messages
- ●All Hospital/Urgent Care/ER Records
- ●Psychiatry/Psychology/Mental Health Records
- ●All Consults
- ●Problem List/Diagnosis List
- ●Lab Results
- ●Progress Notes
- ●All Imaging

Please initial the following:

_____Alcohol/ drug treatment
_____HIV related information
_____Mental health information
_____Genetic Testing

Step 4: Purpose for disclosure is at the request of the individual based on the following:

_____ Continuity of Care
_____ Providing access to records to another Individual who is not the patient/guardian
Other Reason: _____

Step 5: Conditions of Authorization

I have the right to revoke this authorization at any time by writing to Chester County Pediatrics at the above address and revoking my permission. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
I understand that signing this form is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations.

This authorization is **valid for 365 days** for the release of information as indicated by date of signature below.

_____ _____
Patient/Guardian Signature & Date
If not the patient, name and authority to sign on their behalf & date