INCOMING

765 LIBERTY ST, SUITE 111
MEADVILLE, PA 16335
PHONE 814-336-6384
FAX 814-724-2771

MEDICAL RECORD RELEASE AUTHORIZATION FORM

The following information is required by law before we can release the medical records of your child. (See PA Code § 5100.33.)

PATIENT NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____
CITY/STATE/ZIP: _____ PHONE: _____

I, the undersigned, hereby:

☐ Authorize

Name _____
Address _____
City/State/Zip _____
Phone _____ Fax _____

To release my Protected Health Information to **MEADVILLE PEDIATRICS, PC. 765 LIBERTY STREET, SUITE 111 MEADVILLE, PA 16335**
ELECTRONIC CCD CAN BE SENT TO: practice@meadvillepediatrics.medentdirect.com THIS IS NOT AN EMAIL ADDRESS

Reason for request (please check one):

☐ Transfer to another provider ☐ Legal Issues ☐ Appointment with specialist
☐ Personal Use ☐ Insurance Purposes ☐ Other_____

INFORMATION TO BE RELEASED:

☐ Entire Record ☐ Immunization Record Only ☐ Laboratory Results _____
☐ Other Specified Records_____ Dates: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. ☐ Do not release
A CHECK MARK IS REQUIRED to release information from a licensed mental health facility, licensed drug and alcohol facility.
☐ Drug/Alcohol ☐ Mental Health (Psychiatric)

PATIENT'S RIGHTS REGARDING THIS RELEASE OF RECORDS

- I authorize the release of copies of medical records and/or other information as noted above.
- I authorize this information be released by routine mail, inter-office mail, fax, Direct Message, or pick up.
- I understand that I may revoke this authorization at any time, in writing. If not revoked earlier, this consent will remain in effect for thirty (30) days from the date signed below.
- I understand that if the person or entity that receives the described records is not subject to federal privacy regulation or laws, the records may be re-disclosed and no longer protected by those regulations.
- I understand that the healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may refuse to sign this authorization.

_____ _____ _____
Date of Signature | Signature of Patient or Parent/Guardian | Printed name of Patient or Parent/Guardian

_____
Relationship to patient if signer is not the patient

If you are the legal representative of the person listed above, please check the basis for your authority:

☐ Power of Attorney (attach copy)
☐ Guardianship (attach copy)
☐ Parent of Minor
☐ Other_____specify and attach copy

_____
Witness Date

Rev 09/22