765 Liberty Street, Suite 111
Meadville, PA 16335
814.336.6384
814.724.2771

Meadville Pediatrics

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 **Meadville Pediatrics, PC** to release my Protected Health Information to the following person(s)/organization(s):

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

OR

☐ Authorize _____ Fax _____
to release my Protected Health Information to: **MEADVILLE PEDIATRICS, PC, ATTN: OFFICE RECORDS 765 LIBERTY STREET SUITE 111, MEADVILLE, PA 16335**

Reason for request (please check one):

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

Documents can be released electronically if original records are stored on electronic media. If you wish to have records transferred on a CD, please check to see if your health information is available for electronic release. Fees for electronic media are listed below.

INFORMATION TO BE RELEASED:

☐ Entire Record ☐ Immunization Record Only ☐ Laboratory Results _____
☐ Other Specified Records _____ _____

***Please note: We do not copy information generated by other physicians/offices.**

The following information will be released with your electronic visit summary: (when applicable)

Meaningful Use

☐ **Diagnostic Tests**	☐ **History & Physical Exam**	☐ **Rehabilitation Records**
☐ **Problem List**	☐ **Operative Report**	☐ **EKG Reports**
☐ **Medication List**	☐ **Pathology Report**	☐ **Physician Progress Notes**
☐ **Allergies**	☐ **Nurses Notes**	☐ **Radiology Reports**
☐ **Consultation Reports**	☐ **Physicians Orders**	☐ **Vital Signs (growth chart included)**
☐ **Discharge Summary**	☐ **Discharge Instructions**	☐ **Family/Social History**
☐ **Emergency Department Reports**	☐ **Laboratory Tests/Results**	☐ **Immunization Record**

HIV and Mental Health Information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

Do not release: ☐ **HIV** ☐ **Mental Health** ☐ **Drug & Alcohol**

Copy Fee:

1. I understand there is a charge for copying and handling my request. There is a $5.00 fee for my records to be released on CD(compact disc) for personal use. Per Pennsylvania State guidelines, Meadville Pediatrics, PC has 30 business days to release your medical records.
2. Requests for paper copies by the patient/parent will be charged per page plus postage/shipping if mailed as follows:
   a. Amount charged per page for pages 1-20 $1.44
   b. Amount charged per page for pages 21-60 $1.06
   c. Amount charged per page for pages 61-end $0.35
3. Requests for records to be transferred to another physician or health care provider will not be charged for the first request. Additional requests will be charged the above rates.

I authorize the release of copies of medical records and/or other information as noted above. If specifically indicated by me above, I understand that this may include information concerning the following: psychiatric/psychotherapy records, mental health records, drug and alcohol treatment information, specific confidential HIV-related information, and/or any general physical condition information. I authorize this information be released by routine mail, inter-office mail, fax, or pick up. I understand that I may revoke this authorization at any time to the extent that the person is to make the disclosure has already acted in the reliance on this authorization. If not revoked earlier, this consent will remain in effect for thirty (30) days and will only be accepted if completed in its entirety.

_____ _____ ☐Patient ☐ Parent or Legal Guardian ☐Power of Attorney

Date of Signature Signature of Patient or Parent/Guardian (if patient is under 18)