Hanover Pediatric Associates, P.C.
Authorization for Release of Medical Information

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Hanover, PA 17331
Phone: 717-632-3911
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I hereby authorize the use/disclosure of my/my child's health information as described below. **I UNDERSTAND** that this authorization is voluntary**. I UNDERSTAND** that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. **I UNDERSTAND** that a photocopy or fax of this authorization is as valid as the original. **I UNDERSTAND** that I must provide identification with this release in order for it to be valid.

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____

Please release my healthcare information from:

Name of Provider:
_____

Address: _____
City/State/Zip: _____
Phone: _____

Please send my healthcare information to:

Name of Recipient:
_____

Address: _____
City/State/Zip: _____
Phone: _____

INFORMATION TO BE RELEASED

☐ The most recent one (1) year of pertinent information (chart notes, labs, specialist notes, vitals, immunizations)
☐ Specific information (please specify) _____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE:

☐ Sharing with other healthcare providers
☐ Medical/Legal
☐ Moving
☐ Personal use
☐ I am transferring my care to a new healthcare provider
☐ Insurance change

PATIENT AUTHORIZATION:

I UNDERSTAND that my medical records are confidential. **I UNDERSTAND** that by signing this authorization I am allowing the release of my requested medical information to the agency or person specified above.

I UNDERSTAND that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), mental health records, drug and alcohol treatment records, or ADD/ADHD treatment records.. Hanover Pediatric Associates, P.C. is specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

I UNDERSTAND that I have a right to a copy of my Protected Health Information (PHI) for a fee or to inspect the disclosed (PHI) information if so requested. All medical records are **mailed** to the physician's office and will be copied at no charge the **FIRST TIME**. For additional copies to the patient, charges will be assessed at a per page rate.

I UNDERSTAND that I may revoke this authorization at any time by notifying Hanover Pediatrics Associates in writing. I understand that this revocation will not apply to information that has already been released in response to this authorization. This authorization expires in/on _____. (Insert applicable date)

Parent or guardian's signature: _____Relationship to Patient:_____

Witness Signature: _____Date: _____