Sewickley Valley Pediatrics
<u>Authorization to Release Protected Health Information</u>

Section A:

Patient Full Name: ________________________________
Date of Birth: ________________________________
Address: ________________________________
Phone Number ________________________________
Other name(s) under which records may be filed:
____

Records to be released for the purpose of:
_____ Transfer to another medical practice _____ Specialist appointment

Please select the specific timeframe of the records to be released (please choose only one option)
_____ Birth to Present _____Specific Year(s) Detail what years ________
Patient defined time frame (please be specific) ______________________________

Section B:

Information requested (Please check appropriate options)
_____ All Health Information _____ History and Physical exams only (dates:_____________)
_____ Laboratory Reports only _____ Radiology reports only
_____ Consultation reports (specify) ____
_____ Billing and Financial information (specify) ____
_____ Other (specify) ____

_____ **I DO** give my permission for the release of information with regard to mental health treatment, information related to HIV and/or AID status, information regarding drug and alcohol abuse, and/or sexually transmitted diseases.

_____ **I DO NOT** give my permission for the release of information with regard to mental health treatment, information related to HIV and/or AID status, information regarding drug and alcohol abuse, and/or sexually transmitted diseases.

<u>I request and authorize Sewickley Valley Pediatrics to release the designated information to:</u>

Name of Practice or Physician:____
Phone Number: ____
Direct Address (Secure Email): ____
Parent Email: ____

Effective 4/4/2016 SVPAM will **ONLY** transfer records electronically via secure email. If the practice you are transferring to does not have an email address to accept medical records the family will be responsible for providing us with a personal email address so we can transfer records electronically. The family will then be responsible for providing the records to the new physician.

Please be sure you print/save your records promptly when receiving your email. Patient portal access will be disabled two weeks from the date the email is generated.

I understand that this permission will also cover medical records that may have been forwarded to you from a previous physician unless I indicate otherwise below.

_____ I do not want records forwarded from any previous physician

I understand that this authorization will be in effect for a period of 12 months from the date indicated below unless otherwise detailed in writing. No time frame may exceed one year form the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized to release the information.

I am aware that there may be fees associated with record transfer. These fees are established by the federal government and Sewickley Valley Pediatrics abides by the limits that are set for this service.

Additional Patient Rights/Responsibilities

*Release of records will be for the purpose stated on this form. Only those items checked off or listed will be released.

*Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, that Sewickley Valley Pediatrics and its staff/employees have no responsibility or liability as a result of any re-disclosure and such information would no longer be protected by the Privacy Rule (HIPAA).

*My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.

*My decision to revoke the Authorization (if needed for payment purposes) may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of that claim.

*Sewickley Valley Pediatrics can not require me to sign the Authorization in order to receive treatment.

*I am entitled to a copy of this completed Authorization form.

________________________   _______________

Patient Signature (18+yrs)   Date

__________________________   _________________

Patient Parent or Personal Representative   Relationship

***Patients 14 years of age or older may authorize release of mental health information. A minor may authorize release of drug and alcohol treatment information without parental consent.**