## Sewickley Valley Pediatrics
## Authorization to Release Protected Health Information

**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:**

_____Specialist Appointment _____Personal Use _____Transfer to another practice
_____Other (Please detail:_____)

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**Section B:**

**Records to be released ~ please choose only one option:**

_____Medical Records Summary (includes office notes, lab and diagnostic tests, problem list, medication list, immunization records ~ within the last two years patient was seen at SVPAM)
_____Immunization record, growth chart & last well visit detail ONLY
_____Entire Medical Record, birth to present
_____All Records for a specific time frame: From ___/___/___ to ___/___/___

**Please choose one:**

_____ **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.

**I request and authorize Sewickley Valley Pediatrics to release the designated information to:**

Name of Practice or Physician:_____
Address: _____
Phone Number: _____Fax Number:_____
Direct Address (Secure Email): _____

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**Section C:**

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

_____ _____

Parent or Personal Representative signature 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.**