PEDIATRIC, ADOLESCENT SURGICAL ASSOCIATES, P.C.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THIRD PARTIES

Patient Name: ______________________________ Date of Birth: ___________________________

Patient Address: ___________________________ SSN: ___________________________________

___________________________ Patient # _________________________________

By signing below, you hereby authorize Pediatric, Adolescent Surgical Associates, P.C. to release or disclose information about you or your child (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

I am requesting the following medical information to be released or disclosed. **Initial one option only.**

__________ Date of Service or specific records to be released: ___________________________________

OR

__________ Authorization to release all medical records.

If you do NOT want certain medical information released or disclosed, please specify by date of service, test, etc.

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Identify the name of the Doctor or person to send the above requested records:

Name ____

Address ____

Expiration date or an expiration event.
Unless dated differently, authorization is valid for one (1) year. ____

This information about you or your child is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information released or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

_____________________________________ _____________________________________

Signature of Parent or Legal Guardian Date
OR
Patient if 18 years old or older or emancipated

I have authority to act for the patient because I am:

____

Relationship to patient