PENNRIDGE PEDIATRIC ASSOCIATES
PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Information to be released: ***CHECK ONE BOX BEFORE MOVING ON:***

- ☐ All pertinent medical records **including mental health, psychological testing, substance abuse and/or HIV related information (AIDS related testing). (*DO NOT FAX*)**
  **** Release must be signed by patient if over 14 yrs per PA State Law for mental health or psychological testing.**
- ☐ All pertinent medical records.
- ☐ All pertinent medical records except: _____

I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and therefore no longer protected under federal privacy regulations.

Please Print Patient Name(s):

_____ BD: _____
Last First

_____ BD: _____
Last First

Use other side for additional names.

I authorize Pennridge Pediatrics Associates (PPA) to release information from my or my child (ren's) medical record as indicated below:

TRANSFER TO:

_____
Physician's name

_____
Street Address City State Zip

_____
Phone Number Email Fax Number

Please Note: Medical Records will be sent via Secure Direct Message, Mail, Email or Fax within 5 business days. We MUST have a phone number if we are emailing records.

Reason for transfer of records:

- ☐ Age of children
- ☐ Non-participating insurance
- ☐ Relocating
- ☐ Dissatisfied with practice, please explain: _____
- ☐ Other, please explain: _____

Parent/Guardian Signature: _____ Relationship to patient: _____

Print: _____ Date: _____

Patient Signature is also required for all patients over the age of 14 for mental health and/or psychological records

Patient Signature(s): _____ _____

Print: _____ Date: _____ Print: _____ Date: _____

Office Use Only: Date Received: _____ Date Sent: _____ Initials: _____