PENNRIDGE PEDIATRIC ASSOCIATES
PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME (s)
Please Print

_____ BD: _____
LAST FIRST

_____ BD: _____
LAST FIRST

_____ BD: _____
LAST FIRST

Use the other side for additional names.

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

MAIL TO:

Pennridge Pediatrics
711 Lawn Avenue
Sellersville, PA 18960

or

Pennridge Pediatrics
270 Main Street
Harleysville, PA 19438

OR FAX TO: **215-257-8735** (SV office) or **215-256-6130** (HV office)

NOTE: 10 pages maximum

DO NOT SEND RECORDS ON CD!

I understand that my request to fax this medical record may compromise patient's confidentiality.

Information to be released:

- ☐ All pertinent medical records **including mental health, psychological testing, substance abuse and/or HIV related information (AIDS related testing). (DO NOT FAX)**
- ☐ 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 thereby no longer protected under federal privacy regulations.

Signature: _____ Relationship to patient: _____
Patient/parent/guardian

Print: _____ **Date:** _____