HIPAA Authorization Form for Release of Medical Record Information

In the State of Pennsylvania, the physician who creates the patient's medical records is the owner of those records. Current Pennsylvania Law states that a PHOTOCOPY of the medical record may be released to the patient or the patient's representative upon proper request within a reasonable period of time. "Proper Request" means a request in writing, and the form below may be used for that purpose. Please note that the law allows the physician a "Reasonable Period of Time" to comply with your request. It also permits the office to charge a Reasonable Fee for preparing the copy.

Patient Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Telephone_____ (Parent's work or cell phone_____)

I hereby authorize _____ to use or disclose the protected health information for the above named patient as described below.

The following person, physician, group or entity may receive disclosure of protected health information for the above named patient:

Name and **complete** address _____
_____
_____

Dates of Service _____ Most recent two (2) years
_____ Specific dates of service _____

Unless you sign here, NO information about alcohol/substance abuse, HIV/AIDS or mental health issues, including ADD and ADHD, will be disclosed. ***One signature required here*** **(ANY PATIENT AGE 14 AND OVER MUST PROVIDE THE SIGNATURE HERE)**

YES, disclose this information_____
NO, do NOT disclose this information_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and then would no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying _____ in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of the above named patient on whether or not I sign the authorization.

My purpose for/intended use of this information is _____

This authorization will expire in one (1) year after the date on this request.

FEES FOR COPIES: FEDERAL AND STATE LAW PERMITS A FEE TO BE CHARGED FOR THE COPYING OF PATIENT RECORDS.

_____	_____	_____
Signature of patient if 18 years of age or older	Date	SSN or Date of Birth
_____	_____	_____
Signature of patent or guardian for minor child	Date	Relationship or authority

Is there a custody issue with this child? ☐ - Yes ☐ - No Initial_____

What is your current insurance:_____

One signature required here

This form must be fully completed before signing and requires signature in two (2) places.