Carlisle Pediatric Associates, P.C.
804 Belvedere Street, Carlisle, Pa. 17013
P: 717-243-1943 F: 717-243-6708

**** ALLOW 7-10 DAYS FOR RECORDS TRANSFERS ****

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

THIS AUTHORIZATION WILL NOT BE ACCEPTED UNLESS IT IS COMPLETED IN ITS ENTIRETY.
All information must be filled in and all questions must be answered for release to be processed.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient Name: _____ **Date of Birth**: _____ / _____ / _____

Organization To Provide Information

CARLISLE PEDIATRIC ASSOCIATES
804 Belvedere Street
Carlisle, Pa. 17013
Phone: 717-243-1943
Fax: 717-243-6708

Organization To Receive Information

Name: _____
Address: _____
City/State: _____
Phone: _____-_____-_____
Fax: _____-_____-_____

Reason for transfer-_____

Is this Authorization for specific records only? ____ NO ____ YES
If yes, specify **what** records and **date of service:** _____

I understand that I have no obligation to disclose information from my record and understand that I may revoke this authorization at any time in writing, except to the extent that action based on the consent has already been taken. I fully understand the contents of this authorization and voluntarily consent to the release of the information stated. Refusal to sign this authorization will not affect my ability to obtain treatment. My signature authorizes release of information by routine mail or fax.

⊗ _____ ___/___/_____ _____
Signature of Parent, Legal Guardian, or Patient if 18 years old **Date** **Relationship to Patient**

_____ _____-_____-_____
Print Your Name **Your Contact Phone Number**

PLEASE TURN PAGE AND COMPLETE BACK

(You must also sign below if any of the following issues are addressed in the chart)
ADD/ADHD, Mental Health, Substance Abuse, HIV Related Information

If this information being disclosed to the above person, organization or agency is from records whose confidentiality may be protected by the **Drug and Alcohol Act (Pa. Law Act 63) and/or the Mental Health Procedures Act (Pa. P.L. 817) and/or Confidentiality of Alcohol and Drug Abuse Patient Record Regulations (Federal Public Law 93-282) and/or Confidentiality of HIV Related Information Act (Pa Law, Act 48)** this information must be released with a separate signature.

My signature authorizes release of above-mentioned information by routine mail or fax.

⊗ _____ ___/___/_____ _____

Signature of Parent, Legal Guardian, or Patient if 18 years old **Date** **Relationship to Patient**

****It is our policy that we are only able to refill medications for 30 days after this form is signed.****

I have read and agree to this policy.

⊗ _____ ___/___/_____ _____

Signature of Parent, Legal Guardian, or Patient if 18 years old **Date** **Relationship to Patient**

This authorization will expire 1 year from the date signed, unless otherwise designated.