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

Received by:_____
Transferred by:_____
Date Transferred:_____

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		**Organization To Receive Information**
Name:	_____	**CARLISLE PEDIATRIC ASSOCIATES**
Address:	_____	**804 Belvedere Street**
City/State:	_____	**Carlisle, Pa. 17013**
Phone:	_____-_____-_____	**Phone: 717-243-1943**
Fax:	_____-_____-_____	**Fax: 717-243-6708**

(PLEASE DO NOT SEND RECORDS ON DISK)

I authorize this disclosure of Protected Health Information for the following reason: (please check one)

Is this Authorization for the purpose of **transferring your care**? ____ NO ____ YES
Please Provide: Vaccine Records, All Well-Child Physicals, last 2 years Sick Encounters, Current Medication List, Current Problem List, Hospitalizations, Specialist Correspondence, and Patient & Family Medical History Summary

Is this Authorization to have records for your own use? ____ NO ____ YES
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. Unless this release is for initial records to be obtained for a new patient to our practice, refusal to sign this release will not affect ability to receive care. I understand this authorization expires in 90 days unless otherwise specified. 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**

*** **You must also sign below if any ADD or ADHD issues are addressed in the chart** ***
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 148)** this information must be released with a separate signature.

⊗ _____ ___/___/_____ _____
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.