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Authorization to Disclose Protected Health Information
**IF YOU ARE TRANSFERRING RECORDS TO ANOTHER FACILITY FROM
 CONCORD PEDIATRICS, PA**

 Patient's Full Name Date of Birth

I authorize Concord Pediatrics, PA to share my health information with:

Name of Person/Entity: _____
 Street Address: _____
 City: _____ State: _____ Zip code: _____
 Telephone Number: _____

I would like my records mailed to the above name/address **or** if I prefer to pick up the records, please contact me at this number when the records are available for pick up: _____

For the following purposes:

Provider Transfer Other (specify): _____

Type of information requested:

Abstract (includes any available documents below Other health information
 Or check only those documents needed): Assessments Nurses' Notes
 Progress Notes Emergency Dept Notes Itemized Bill
 History & Physical Consultation Other _____

Dates of care to be released: _____ to _____

I UNDERSTAND THAT:-Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.

Once I authorize the disclosure of my health information, it is no longer protected information and re-disclosure by the recipient is legally permitted.

The following types of information WILL BE INCLUDED UNLESS INDICATED BY YOU INITIALING BELOW:

Drug and/or alcohol treatment Initials:____ Psychiatric Initials:____
 Sexually transmitted disease Initials:____ Genetic Treatment Initials:____
 HIV (AIDS) testing/treatment Initials:____

This authorization expires six months from the date of signature or on: _____

 Signature of patient or legal representative/guardian Authority or relationship of representative Date