AUTHORIZATION FOR THE RELEASE OF PROTECTED PATIENT INFORMATION

1. PATIENT INFORMATION

Patient last name_____**First name**_____**MI**_____**DOB**_____

Patient address_____
City, State, Zip

Home phone __(_____)_____**Alternate phone**___(_____)_____

2. INFORMATION TO BE DISCLOSED

I hereby authorize _____ at _____
Provider name Provider address

_____ _____
City, State, Zip Provider phone number

to release my entire medical record or the following specific parts of my medical record _____

_____

To: **Kids Plus Pediatrics**

_____	810 Clairton Blvd Pittsburgh, PA 15236	**FAX: 412.466.7137**
_____	4070 Beechwood Blvd Pittsburgh, PA 15217	**FAX: 412.521.6512**
_____	671 Castle Creek Drive Seven Fields, PA 16046	**FAX: 724.778.8959**

I understand the information to be released or disclosed may include protected information relating to mental health, developmental disabilities, alcohol and/or drug abuse, sexually transmitted diseases, and HIV testing.
I authorize the release or disclosure of this type of information.

3. PATIENT RIGHTS AND PRIVACY

I understand the following:

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization
- The information released in response to this authorization may be re-disclosed to other parties
- My treatment or payment for treatment cannot be conditioned on the signing of this authorization
- This authorization is valid for the disclosures of the specified health information to the recipient above for a period of one year and it automatically expires 12 months after the date it is executed.

4. PURPOSE OF INFORMATION RELEASE

□ Further medical care	□ Legal investigation	□ Applying for insurance
□ Payment of insurance claim	□ At the request of individual	□ Other (specify)_____

5. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____ _____
Signature Date

If personal representative, print name _____

If patient is a minor, please check the relationship of the personal representative to the patient:
□ Parent □ Legal Guardian □ Other (Describe) _____