



**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) \_\_\_\_\_