# AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT INFORMATION

Patient Last Name | First Name | MI | Date of Birth

Street Address | City | State | Zip Code

**Records I Would Like Released:**

- ☐ All Records From the Last Two Years (including Well Visits, Sick Visits, and Phone Messages)
- ☐ Immunization Records & Growth Chart
- ☐ Specialist Notes From the Last Two Years
- ☐ Other (Please Specify): _____

**I authorize the medical records listed above to be released by:**

Medical Provider Name | Address | Phone #

**I authorize the medical records listed above to be released to KIDS PLUS PEDIATRICS at:**

- ☐ Cranberry/Seven Fields Office | 671 Castle Creek Drive, Seven Fields PA 16046 | Fax: 724.778.8959
- ☐ Pleasant Hills Office | 810 Clairton Blvd, Pittsburgh PA 15236 | Fax: 412.466.7137
- ☐ Squirrel Hill/Greenfield Office | 4070 Beechwood Blvd, Pittsburgh PA 15217 | Fax: 412.521.6512

**I understand that:**

- I may revoke this authorization at any time, in writing, before the information has been released;
- The released information may be released to other parties as necessary and appropriate.

**Purpose of Medical Record Release:**

- ☐ Medical Care
- ☐ Legal Investigation
- ☐ Insurance Claim
- ☐ Insurance Application
- ☐ Other (Please Specify) _____

**Signature of Patient or Personal Representative**

Name | Date

If Personal Representative, Print Name _____

Relationship _____

**This authorization expires 1 year after the date of the signature above.**