HIPAA Authorization Form for Release of Medical Record Information

In the State of Pennsylvania, the physician who creates the patient's medical records is the owner of those records. Current Pennsylvania Law states that a PHOTOCOPY of the medical record may be released to the patient or the patient's representative upon proper request within a reasonable period of time. "Proper Request" means a request in writing, and the form below may be used for that purpose. Please note that the law allows the physician a "Reasonable Period of Time" to comply with your request. It also permits the office to charge a Reasonable Fee for preparing the copy.

Patient Name_______________________________________ Date of Birth___________

Address_________________________ City________________ State_____ Zip________

Telephone________________________ (Parent's work or cell phone_________________)

I hereby authorize **Lancaster Pediatric Associates, LTD.** to use or disclose the protected health information for the above named patient as described below.

The following person, physician, group or entity may receive disclosure of protected health information for the above named patient:

Name and **complete** address ____
____
____

Dates of Service _____ Most recent two (2) years
_____ Specific dates of service ____________________________

Unless you sign here, NO information about alcohol/substance abuse, HIV/AIDS or mental health issues, including ADD and ADHD, will be disclosed. ***One signature required here*(ANY PATIENT AGE 14 AND OVER MUST PROVIDE THE SIGNATURE HERE)**

YES, disclose this information____
NO, do NOT disclose this information___________________________________

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and then would no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying **Lancaster Pediatric Associates, LTD.** in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of the above named patient on whether or not I sign the authorization.

My purpose for/intended use of this information is ________________________________

This authorization will expire in one (1) year after the date on this request.

FEES FOR COPIES: FEDERAL AND STATE LAW PERMITS A FEE TO BE CHARGED FOR THE COPYING OF PATIENT RECORDS. LANCASTER PEDIATRIC ASSOCIATES, LTD. HAS CONTRACTED WITH *HEALTH PORT* TO MAKE COPIES. *HEALTH PORT* WILL SEND AN INVOICE WHICH CAN BE PAID BY CHECK OR PAID ONLINE AT WWW.HEALTHPORTPAY.COM. IF YOU HAVE ANY FURTHER QUESTIONS, YOU MAY CONTACT *HEALTH PORT* AT (800) 464-0035. (FEE SCHEDULE ON REVERSE SIDE.)

____________________________ ____________________________ ____________________________
Signature of patient if 18 years of age or older | Date | SSN or Date of Birth

____________________________ ____________________________ ____________________________
Signature of patent or guardian for minor child | Date | Relationship or authority

Is there a custody issue with this child? Yes________ No________ Initial________

What is your current insurance:____

One signature required here

This form must be fully completed before signing and requires signature in two (2) places.

Made Fillable by eForms