254 Moraine Pointe Plaza Butler, Pa 16001

Phone 724-283-5437 Fax 724-285-5437

HIPPA AUTHORIZATION RELEASE OF PROTECTED MEDICAL RECORDS

Date: _____ Request will expire after 90 days of this date.

Patients Name: _____ DOB: _____

Address: _____ Phone: _____

I hereby authorize_____ to release the following medical records to Quick Care Pediatrics for continued care.

__Consults __Medication Records

__Discharge Summary/Instructions __Operative Report

__Laboratory Reports/Test __Physician Orders

__Emergency Dept. Reports __Progress Notes

__Medical History/Physical Exam __Psychiatric/Psychological Eval

Other:_____ Specific dates:_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would no longer be protected by federal privacy regulations. I may revoke this authorization by notifying the facility in writing of my desire to revoke it. 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 provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicate. __Do not release

Parent/Guardian Signature _____ Date of Signature_____