HERSHEY PEDIATRIC CENTER

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*** *IF RECORD COUNT IS OVER 20 PAGES, PLEASE SEND BY MAIL* ***

MEDICAL RECORD RELEASE FORM

Patient Authorization to Release Medical Records

Patient Name_____ Date of Birth_____

Address_____
Street City State Zip

I hereby authorize **Hershey Pediatric Center** to

____Release to or ____Receive from

Name_____ Phone_____

Address_____
Street City State Zip

____I do ____I do **NOT** Authorize release of information related to AIDS or HIV Infection, psychiatric or psychological care, substance/alcohol abuse to treatment, as this is specially protected by state and/or federal laws.

Purpose of disclosure:

___Referral to Specialist ___Change of Doctor/Moving

___Insurance purposes ___Legal Matters

___Personal ___Parental Access to Patient Information

I have read this authorization and understand what information will be used or disclosed. I specifically authorize and current employee or owner of Hershey Pediatric Center to disclose my protected health information as described on this form to the recipient(s) listed on this form. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

Parent/Legal Guardian: _____ Date: _____

* The effective date of this authorization, and the recipients of the protected health information according to this authorization.
* The patient/parent's desire to revoke this authorization and
* The date of the revocation, and the patient/parent's signature.

The revocation MUST be addressed to:
Privacy Office/Office Manager Melissa Jumper

This authorization shall expire as the following date or event

_____.

If no date is indicated, this release of information will expire in one year from the date it was authorized.

_____

* In the state of Pennsylvania, the physician who created 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 this form may be used for that purpose. Please note that the law allows a 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.