

## AUTHORIZATION FOR RELEASE OF INFORMATION

Please release records to Village Pediatrics of Chapel Hill, PA

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I authorize the use or disclosure of the above named individual's protected health information as described below.  
**This information is to be released from (previous physician):**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
\_\_\_\_\_

**Information to be released:** (specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc.) \_\_\_\_\_  
\_\_\_\_\_ *vaccine records and medical summary* \_\_\_\_\_

**Purpose of Disclosure:** \_\_\_\_\_ *continuation of care* \_\_\_\_\_

I understand that this authorization will expire 6 months after I have signed this form \_\_\_\_\_.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer e protected by Federal privacy regulations.

Signature of Patient/Parent/Legal Guardian \_\_\_\_\_

Relation to patient \_\_\_\_\_ Date \_\_\_\_\_

Records received by \_\_\_\_\_



*It Takes a Village...*