

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 protected by Federal privacy regulations.

Signature of Patient/Parent/Legal Guardian _____

Relation to patient _____ Date _____

Records received by _____



It Takes a Village...