PAK PEDIATRICS

NEPA BREASTFEEDING CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION
TO PEDIATRIC ASSOCIATES OF KINGSTON

Patient Name ____ Date of Birth ___/___/___________
First MI Last

INFORMATION TO BE RELEASED FROM:

Name of Facility or Provider		
Address		
City	State	Zip
Phone#	Fax#	

INFORMATION TO BE RELEASED TO:

PAK PEDIATRICS
451 3rd Avenue
Kingston, PA 18704-5802
O:570- 288-6543 F:570-288-7130

INFORMATION TO BE RELEASED: (check one)

______ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
______ All medical records
______ Specific information (please specify)

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

______ Attorney ______ Insurance ______ Doctor ______ Personal

The information to be released will cover the time period from ______________ to ________________

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

***EXCLUDE** the following information from the records released (please initial)

______ Drug/ Alcohol abuse/treatment & diagnosis ______ Sexually transmitted disease

______ HIV/ AIDS diagnosis/ treatment/ testing ______ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

Signature: ____ Date: ______________________________

(Patient, guardian*, or authorized representative*)

This authorization will expire 90 days from the date signed

Possible copying fee required