Manchester Pediatric Associates LLC

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Authorization for Release of Health Information (Medical Records)

Patient Information (Please print clearly)

1)Patient Name:_____DOB:_____

2)Patient Name:_____DOB:_____

Address:_____

Phone:_____

I, the undersigned authorize Manchester Pediatric Associates to Receive / Disclose protected health information from the below entity:
Organization Name/ Previous
Doctor:_____

Address:_____

Telephone:_____Fax:_____

How may your records be released? _____Copies by mail _____Copies by fax

I authorize the release of records for the following purpose:

_____ At the request of the patient or patient's legal representative

_____Other_____

Please disclose/ receive the following records:

Entire Medical record _____ Immunization records_____Last Physical_____Labs_____

My authorization is given freely and with the understanding that:

- I may refuse to sign this authorization: the health center may not condition my treatment on my provision of this authorization. However, the health center may charge a fee for copying and first class postage related to the use/disclosure of my health information under this authorization.
- I may revoke this authorization at any time by written request to the health center except where information has already been release in reliance on my authorization.
- This authorization is valid for ONE YEAR from the date I signed it
- The information may be subject to redisclosure by the recipient and may no longer be protected by the health centers privacy practice or applicable privacy law.

Patient or patient's personal representative with legal authority to act for the patient MUST sign and date this authorization for it to be valid.

Signature of Patient or Patient Rep:_____Date:_____

Relationship:_____