AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ Date of Birth _____

I hereby authorize North Willow Grove Pediatrics, 2510 Maryland Road, Suite 160, Willow Grove, PA 19090 to disclose a copy of health and medical information to:

Recipient Name:_____
Electronic Fax #: _____

PURPOSE OF THIS DISCLOSURE:

____Transferring to New Physician _____ Personal Use ____ Specialist Request

INFORMATION TO BE DISCLOSED:

_____Date Range: _____ to _____

OR

_____Last Well Exam, Growth Chart, and Immunization Record

OR

_____ Other : _____

YOUR RIGHTS REGARDING THIS AUTHORIZATION

Right to inspect or receive a copy of the health information to be used or disclosed: I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact North Willow Grove Pediatrics. I am aware that my withdrawal will not be effective to uses and/or disclosures of my health information that the person(s) or organization(s) listed above have already made in reference to this authorization. North Willow Grove Pediatrics will not condition treatment on the completion of this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

Further Disclosure**:** I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

_____ _____
Patient or Legal Representative Signature/Relationship Date

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of health information relating to testing, diagnosis and treatment for:

AIDS/HIV/STDs Mental Health Care Alcohol/Drug Use Developmental Disabilities

_____
Patient or Legal Representative Signature/Relationship Date of Signature

Office Use:

_____ Changed to Inactive in OP _____ Staff Initials