HERITAGE VALLEY PEDIATRICS

AUTHORIZATION FOR RELEASE OF INFORMATION TO ANOTHER PRACTICE

(Please print clearly)

Paper copies Note that there will be a **charge** for the cost associated with copying your records if you are not having them sent directly to your new physician or specialist by us. You will be informed of, and billed for, these charges prior to the release of the copies.

PATIENT INFORMATION

Name: First_____Middle_____Last_____

Social security number_____Date of birth_____

I, THE UNDERSIGNED, HEREBY AUTHORIZE Heritage Valley Pediatrics, Monaca to provide a copy of my medical records (to include doctors' notes and related testing within the past two years, medication list, problem list, most recent EKG, immunization records and living will/advance directives) to the following physian/physician group. The purpose of this disclosure is my transfer to a new primary care physician/practice.

My records should be sent to:

Doctor's Name:_____Phone #_____

Address: Street_____City_____State_____Zip_____

Expressed Authorization: ******Signature Required******

I understand that my medical record may contain information related to:

- ***Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV***
- ***Psychiatric Care***
- ***Treatment for alcohol and/or drug abuse.***

☐I give my consent for release of this information: _____
Signature Date

☐I **DO NOT** give consent for release of this information: _____
Signature Date

This authorization for release of information is valid for 90 days from the date of signature, unless revoked by written notice to the providing institution, provided the notice is received prior to the release of information. I understand that signing this authorization is voluntary, and Heritage Valley Health System cannot deny me treatment for not agreeing to sign this authorization. I understand that once the above information is disclosed, it may not be under control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure. I understand that this authorization may be revoked at anytime. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. *If I have questions about the disclosure of my health information, I may contact the Office Manager or the Privacy Officer of Heritage Valley Health System.* I hereby certify that I have read this authorization and agree to its terms.

_____
Required: Signature of Patient or Parent (if patient is a minor) Date

_____
Signature if other than patient (please attach Power of Attorney documentation) Relationship Date

Prior to December 19, 2018	After December 19, 2018
Fax: 724-770-7948	**Fax:** 724-749-7478
Mail form to: Heritage Valley Pediatrics – Monaca 3542 Brodhead Road Monaca, PA 15061 Attn: Darla Matich	**Mail form to:** Heritage Valley Sewickley 720 Blackburn Road Sewickley, PA 15143 Attn: HIM (Medical Records ROI)

For questions specific to this form, please call 412-749-7186