Pediatric Associates of Lancaster * 1554 Wesley Way Lancaster Ohio 43130 * phone: 740-687-6386 * fax: 740-687-1388
Jennifer Miller MD * Michele Hensley MD * Michelle Golla MD * Rachael Hall CNP

Medical Record Release Form

HIPAA AUTHORIZATION FORM

Patient's Full Name | **Patient's Social Security Number**/Medical Record Number

Address | **Patient's Date of Birth**

City, State Zip Code | **Parent / Guardian Telephone Number**

Parent / Guardian Name

I hereby authorize use or disclosure of protected health information as described below.

Transfer To:		**Transfer From:**	
Name:		**Name:**	
Address:		**Address:**	
Phone #:		**Phone #:**	
Fax #:		**Fax#:**	

The specific information that should be disclosed is:

- ☐ Complete Medical Record
- ☐ Immunization Record
- ☐ Other (please specify): _____

Please note: Medical Records will NOT be accepted on DISC

- I understand that records / protected health information may not be released unless I sign this form.
- I understand that I may revoke this authorization in writing at any time, by sending a written revocation to Pediatric Associates of Lancaster.
- **I understand that this authorization may include information concerning testing, diagnosis or treatment of HIV, AIDS, Psychiatric and/or Drug/Alcohol Treatment and or Assault Records that may be in the medical record.**
- This authorization for release of protected health information is effective for 90 days, or for a maximum of one year from the signed date below.

Signature of Parent/Guardian	**Date of Signature**	**Description of Authority to Act for the Patient**
Printed Name of Parent/Guardian	***Patient Signature*** **(if 18 years of age or older)**	**Patient Date of Signature**

Official Use Only

Received date	**Processed By**	**Completion date**