CHOPRA PEDIATRICS

1224 SEVENTH AVE. ALTOONA, PA 16602

PHONE: 814-944-8784 **FAX**: 814-944-8625

Patient Name: _____ Date of Birth: _____ SSN: _____

Address: _____

I hereby authorize Chopra Pediatrics to:

( ) Obtain records from _____

(Name & address of person or agency)

( ) Release records to _____

(Name & address of person or agency)

The information to be released is (specific documents, time periods, etc.) _____

_____

Purpose or need for the information requested _____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the general HIPAA Privacy Rule.

I understand that I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

General authorization

I understand also that I may revoke this authorization at any time except at the extent that the action has been taken in reliance thereon. The consent will remain in effect no more than ninety (90) days from the date I signed this Authorization in order to accomplish this purpose.

Parent / Patient : _____Date: _____

Relationship : _____

Witness Signature: _____ Date: _____

Special authorization

I understand that my medical records may contain alcohol/drug and/or mental health information and I give special authorization to the healthcare provider/facility to release this information in my records to the person, physician, facility named above for the stated purpose.

I have read this form, or had it read to me, and understand the content. I was given the opportunity to ask questions and have them answered to my satisfaction.

Parent / Patient : _____Date: _____

Relationship : _____

Witness Signature: _____ Date: _____

A copy of this authorization has been _____ accepted _____ rejected by the patient/representative.