The Center for Pediatric & Adolescent Medicine, P.A.

125-1 Greentree Dr. Dover, DE. 19904
P: 302-678-8333 F: 302-674-2298

Release of Medical Records

Patient Name:_____ Date of Birth:____/____/____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Social Security #: XXX- XX- _ _ _ _

I request that my protected health information (PHI) from (Name of Provider/Practice) _____

Address:_____ City_____ State:_____ Zip:_____

Phone:_____

be disclosed to:

Recipient Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____

I authorize the following PHI to be released from my following medical record(s):

- ☐ Well Visits
- ☐ Sick Visits
- ☐ Consultation Reports
- ☐ Hospital Records
- ☐ Lab Reports
- ☐ Radiology Reports

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and/or drug abuse.

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained

Alcohol, Drug, Substance Abuse Records	☐ **Yes**	☐ **No**
HIV Testing and Results	☐ **Yes**	☐ **No**
Mental Health or Psychotherapy Records	☐ **Yes**	☐ **No**

Purpose for requesting information: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time.
- Unless otherwise revoked, this authorization will ***expire on the following date:*** _____
  If I fail to specify an expiration date, this authorization will ***expire one year from the date signed.***
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

I certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

_____ ___/___/___ _____ ___/___/___

(Signature of Patient) (Date) (Signature of Witness) (Date)

If you are signing as a Personal Representative for the about patient, you will be asked to provide proof of your identity and of your authority to sign for the patient.
Please fill out and sign below:

Your Name (please print): _____ Your Relationship to the Patient: _____

Your Signature:_____ Date: ____/____/____

FOR OFFICE USE ONLY:

Information released by:_____ Date: ____/____/____