

BERKS PEDIATRICS
555 RAYMOND ST., STE. 100 READING, PA 19605
PHONE: 610-921-1111 FAX: 610-898-9269
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____
Patient's Full Name Date of Birth Phone Number

Address-Street, City, State, Zip Current Insurance

Do hereby authorize:

_____ Name of Company/Facility/Person

_____ (address)

_____ (address)

_____ (phone / fax)

To Release to:

Berks Pediatrics
555 Raymond St., Ste. 100
Reading, Pa 19605
Phone: 610-921-1111 Fax: 610-898-9269

The following information:

- | | | |
|---|--|--|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Emergency Reports |
| <input type="checkbox"/> Lab Test Results | <input type="checkbox"/> EKG/ Cardiac Cath | <input type="checkbox"/> Other _____ |

____ I do ____ I do not authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care or psychological assessment, and treatment for alcohol and/or drug abuse.

Purpose of Disclosure:

- | | | | |
|---|-------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Insurance | <input type="checkbox"/> Workers Comp | <input type="checkbox"/> Change Of Doctor |
| <input type="checkbox"/> Legal Investigation | <input type="checkbox"/> Disability | <input type="checkbox"/> Personal | <input type="checkbox"/> Continuing Care |

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations.

Signature if individual or guardian or
Personal Representative of patient's estate.

Date _____