



103 Arrandale Boulevard, Exton, PA 19341

p: 610.363.7837 f: 610.363.3923

REQUEST FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____

Phone: (_____) _____ - _____

AUTHORIZES:

Name of previous healthcare provider: _____

Address: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

TO DISCLOSE TO:

Healthy Steps Pediatrics, LLC
103 Arrandale Boulevard
Exton, PA 19341

- * please do not fax more than 20 pages
- * please send only single-sided copies
- * please do not staple pages

DATES OF INFORMATION TO BE DISCLOSED:

From _____ to _____

INFORMATION TO BE DISCLOSED:

- All medical records
- Specific records/information as follows: _____

I DO NOT WANT THE FOLLOWING DISCLOSED:

- Alcohol/Drug Abuse HIV Test Results Mental Health/Developmental Disabilities

EXPIRATION:

This authorization is valid until the following date/event: _____

*Note: If this item is left blank, the authorization will expire one (1) year from the date signed.

PURPOSE:

Further medical care due to:

- Relocation Change of Insurance Coverage For Specialist Review

Other: _____

Insurance Eligibility/Benefits

Disability Benefits

Legal Investigation/Action

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE:

X _____ Date: _____

If signed by a person other than the patient, complete the following:

1) Individual is: a minor legally incompetent or incapacitated deceased

2) Legal Authority: parent* legal guardian next of kin/executer of deceased POA for Healthcare

* By signing above, I hereby declare that I have not been denied physical placement of this child.