Pediatric Dermatology
Associates of Erie LLC
3405 State Street
Erie, PA 16508
Phone: 814.616.0321
Fax: 814.528.5643

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

This release of records allows PDAE to forward specified medical records **to** another individual/entity.

PATIENT NAME _____

DATE OF BIRTH _____

The above listed patient authorizes Pediatric Dermatology Associates of Erie to make record disclosure to:

PHYSICIAN/FACILITY NAME _____

PHYSICIAN/FACILITY ADDRESS _____

CITY, STATE, ZIP CODE _____

PHONE _____ **FAX** _____

Please specify the type(s) of information to be disclosed; check all that apply:
- ☐ Office notes
- ☐ Biopsy/pathology reports
- ☐ Blood work results
- ☐ Other _____

Please specify the date(s) of the information to be disclosed:
- ☐ Two years prior to last appointment
- ☐ All dates of service
- ☐ Specific date of service _____

Please indicate the reason for disclosure of medical records:
- ☐ Transfer to another physician
- ☐ Second opinion on diagnosis/treatment
- ☐ Continuity of care
- ☐ Other _____

Please indicate the mode of transfer of records:
- ☐ Mail
- ☐ Fax
- ☐ Flash drive transfer (All flash drives must be provided by the patient; PDAE does NOT provide flash drives for the transfer of medical records.)

RESTRICTIONS
Only medical records originated through this Pediatric Dermatology Associates of Erie will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

AGREEMENT

1. I understand 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 for alcohol and drug abuse.

2. I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to PDAE. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

4. Processing fee may be charged for medical record preparation and release.

5. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Parent/Guardian Signature _____Date: ___/___/_____
(Guardian or Authorized Representative must attach documentation of such status.)

Printed Name _____Relationship to Patient _____

Address of Guardian/Authorized Representative _____

City, State, Zip Code _____ Phone _____

Signature of PDAE Representative _____Date: ___/___/_____

PDAE Office Use Only:

Information release date _____ Completed by _____