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 TO PDAE

This release requests release of medical records to Pediatric Dermatology Associates of Erie.

PATIENT NAME _____

DATE OF BIRTH _____

The above listed patient requests record disclosure to **Pediatric Dermatology Associates of Erie:**

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 of care
- ☐ Second opinion on diagnosis/treatment
- ☐ Continuity of care
- ☐ Other _____

AGREEMENT
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.

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 _____