MEADOWBROOK PEDIATRICS, P.C.
1650 Huntingdon Pike Suite 320 Meadowbrook, PA 19046 215-947-1447 215-947-2603 (fax)

Release of Medical Information

I hereby request and authorize Meadowbrook Pediatrics, PC to use and disclose protected health information (PHI) as designated below:

This Authorization applies to the following: (please check all that apply)

- ☐ Complete Medical Records
  - Chart Notes
  - Consultation Notes
  - Patient Summary of all visits
  - Radiology/EKG/Lab Reports
  - Immunizations Only
  - Newborn Record (Including maternal prenatal history – Mother must consent)
- ☐ Other (specify): _____

Reason for Request to Release Complete Medical Records:

- ☐ Review by Specialist, Surgeon or Therapist
- ☐ Moving From Area
- ☐ Transferring to Adult Medicine
- ☐ Transferring to different Provider
- ☐ Other: (specify): _____

I wish to receive my records in the following manner (A Medical Records Fee as per our Financial Policy must be paid before the records are prepared):

- ☐ I will download from patient portal (No fee)
- ☐ Electronic media (Please allow 15 business days for completion)
- ☐ Paper (Please allow 15 business days for completion)

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke the Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date(s) of service indicated, and for the purpose written above. Meadowbrook Pediatrics, PC shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

Patient Full Name _____ Date of Birth: _____

Current Address: _____ City/State/Zip: _____

Email: _____ Cell Phone: _____

Signature of Patient or Legal Guardian: _____ Date: _____

If I am not available, I give permission for the person listed below to pick-up my records.

_____ _____

Name Relationship

Date Completed_____ Initials _____
Sent via: Picked-up Mailed Faxed
Fee Paid: Cash, Check or Credit Card
Fee Amount: $_____