

*HIPAA Authorization Form for Release of Medical Record Information*

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In the State of Pennsylvania, the physician who creates the patient's medical records is the owner of those records. Current Pennsylvania Law states that a PHOTOCOPY of the medical record may be released to the patient or the patient's representative upon proper request within a reasonable period of time. "Proper Request" means a request in writing, and the form below may be used for that purpose. Please note that the law allows the physician a "Reasonable Period of Time" to comply with your request. It also permits the office to charge a Reasonable Fee for preparing the copy.

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ (Parent's work or cell phone \_\_\_\_\_)

I hereby authorize INNOVATIVE COUNSELING SERVICES, INC.. to use or disclose the protected health information for the above named patient as described below.

The following person, physician, group or entity may receive disclosure of protected health information for the above named patient:

Name and complete address \_\_\_\_\_

Dates of Service \_\_\_\_\_ Most recent two (2) years \_\_\_\_\_ Specific dates of service \_\_\_\_\_

Unless you sign here, NO information about alcohol/substance abuse, HIV/AIDS or mental health issues, including ADD and ADHD, will be disclosed. \*One signature required here\*(ANY PATIENT AGE 14 AND OVER MUST PROVIDE THE SIGNATURE HERE)

YES, disclose this information \_\_\_\_\_ NO, do NOT disclose this information \_\_\_\_\_

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and then would no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying Innovative Counseling Services, INC. in writing of my desire to revoke. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of the above named patient on whether or not I sign the authorization.

My purpose for/intended use of this information is \_\_\_\_\_ This authorization will expire in one (1) year after the date on this request.

FEES FOR COPIES: FEDERAL AND STATE LAW PERMITS A FEE TO BE CHARGED FOR THE COPYING OF PATIENT RECORDS. LANCASTER PEDIATRIC ASSOCIATES, LTD. HAS CONTRACTED WITH HEALTH PORT TO MAKE COPIES. HEALTH PORT WILL SEND AN INVOICE WHICH CAN BE PAID BY CHECK OR PAID ONLINE AT [WWW.HEALTHPORTPAY.COM](http://WWW.HEALTHPORTPAY.COM). IF YOU HAVE ANY FURTHER QUESTIONS, YOU MAY CONTACT HEALTH PORT AT (800) 464-0035. (FEE SCHEDULE ON REVERSE SIDE.)

Made Fillable by eForms

Signature of patient if 18 years of age or older Date \_\_\_\_\_

Signature of parent or guardian for minor child \_\_\_\_\_ Date \_\_\_\_\_

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SSN or Date of Birth

\_\_\_\_\_ Relationship or authority

Is there a custody issue with this child? Yes \_\_\_\_\_ No \_\_\_\_\_ Initial \_\_\_\_\_ What is your current

insurance: \_\_\_\_\_

\*One signature required here\*

\*This form must be fully completed before signing and requires signature in two (2) places.\*