JDC Pediatrics
2025 Technology Parkway, Suite 108, Mechanicsburg, PA 17050
Phone: 717-791-2680   Fax: 717-791-2686

AUTHORIZATION for the RELEASE of PROTECTED HEALTH INFORMATION

Patient Name(s) ____ Birth Date(s): _____________________

Address ____ Phone (______)___________________

I hereby authorize JDC Pediatrics to:

❑ Release health information to:
(If you are transferring from JDC to another provider)

❑ Receive health information from:
(If you are new to JDC needing records from your previous provider)

Practice/Physician ____

Address ____

Phone Number (______) ______________________ Fax Number (______) ____________________

Reason for requesting this information:

❑ Transfer to adult/family practice
❑ Transfer due to change of insurance
❑ Transfer, moved out of area
❑ Other, please specify____

The information to be released by JDC shall be limited to all pertinent records for the past 2 years, and will be released to the above-named practice/physician by mail or fax.

⏩The information released will include information relating to AIDS or HIV infection, treatment for substance and/or alcohol abuse or dependency, and psychotherapy notes or other information relating to mental health or psychiatric care. If you wish to EXCLUDE this information from the records being released, please initial here____

This information is being disclosed to the above person, organization or agency from records whose confidentiality may be protected by the Pennsylvania Drug and Alcohol Abuse Control Act, the Pennsylvania Mental Health Procedures Act, and/or the Pennsylvania Confidentiality of HIV Related Information Act. My signature below authorizes the release of information protected by these Pennsylvania statutes, unless initialed above.

I understand that I have no obligation whatsoever to disclose information from my record, and that JDC Pediatrics cannot withhold treatment from me based upon my failure to execute this authorization, unless the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. JDC Pediatrics, its employees, officers and clinical staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Finally, I understand that I am entitled to obtain a copy of this authorization from JDC Pediatrics upon request.

THIS AUTHORIZATION SHALL EXPIRE ONE YEAR FROM THE DATE BELOW, UNLESS OTHERWISE NOTED.

_____________________________________ _________________________ __________________________

Patient (18 years or older) or
Parent/Guardian if patient is under age 18

Date

Relationship to Patient