South Philadelphia Pediatrics · 1408 S. Broad St., 2nd floor Philadelphia, PA 19146 · 215-467-3515
Queen Village Pediatrics · 701 S. 2nd St. Philadelphia, PA 19147 · 215-592-0715
Whitman Pediatrics · 2240 S. 3rd St. Philadelphia, PA 19148 · 215-755-2652
www.southphiladelphiapediatrics.com

Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/____

I, _____ hereby authorize the release of medical information

___ TO: South Philadelphia Pediatrics
1408 S. Broad Street, 2nd floor
Philadelphia, PA 19146
Phone: 215-467-3515
Fax: 215-467-0338

___ FROM: Doctor/Clinic/Hospital: _____
Address: _____
_____
Phone:_____
Fax: _____

Please release the following:

___ All health information (including growth charts and vaccination records)

___ History/Physical Exam
___ Discharge Summaries
___ Progress Notes
___ Consultation Reports
___ Radiology/Images
___ Diagnostic Test Reports
___ Lab Results
___ Pathology Reports

___ Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

___ Yes, I consent to the release of this information.

___ No, I do not consent to the release of this information.

Purpose of disclosure:

___ Treatment/ Continuing medical care
___ Change of Physician
___ Personal Use
___ Attorney/Legal
___ Change of Insurance Please Specify your new carrier _____
___ Other _____

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____