

*PEDIATRIC HEALTH ASSOCIATES, P.C.
2860 CAROL ROAD
YORK, PENNSYLVANIA 17402
PHONE (717) 755-3400
FAX (717) 757-3702*

**AUTHORIZATION FOR RELEASE OF
MEDICAL INFORMATION**

I hereby authorize: _____ To release to: _____

any and all medical records and information on my child(ren). The information being released for the purpose of : _____ Continuing Care _____ Insurance _____ Legal _____ Other: _____

This information is being disclosed to the above named person, organization, or agency from records whose confidentiality may be protected by the Drug and Alcohol Abuse Control Act (PA Law, Act 63) and/or Mental Health Procedures Act (PA P.L. 817) and/or Confidentiality of Alcohol and Drug Abuse Patient Record Regulations (Federal Public Law 93-282) and/or Confidentiality of HIV Related Information Act (PA Law, Act 148). My signature below authorizes release of all such information by routine/express mail service or facsimile transaction.

Print Patient's Full Name and Date of Birth

Parent/Guardian Signature *Relationship To Patient*

Witness *Date*

****A copy of this form will be accepted in lieu of an original.****

Records Mailed _____ By _____

So that we may better meet the future needs of our families, would you please tell us your reason for leaving Pediatric Health Associates, P.C.? _____