



Pediatric Associates of Lewiston, P.A.

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Tel. (207) 784-5782 *Fax. (207) 783-9268

REQUEST AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORD

Patient Name: _____ **Date of Birth:** _____

I hereby authorize and request _____

Address: _____

to release patients records to _____

Address: _____

Records requested may include the following: (circle any that you do wish us to obtain/exchange):

- | | | |
|-------------------------|--------------------------------|-------------------------------|
| A. History and Physical | E. X-Ray and or Lab | I. Psychosocial History/eval. |
| B. Discharge Summary | F. Pathology Report | J. Birth Records |
| C. Immunization Record | G. Psychiatric Evaluation | K. Operative Report |
| D. Transfer of Care | H. Psychological History/eval. | L. Other (specify): _____ |

If transferring care please state a reason: _____

I authorize the provider to use or disclose information related to (circle all that apply) [this element is required by State law]:

- A. AIDS/HIV and other Communicable Disease
- B. Behavioral Health Care/Psychiatric Care/Mental Health Information
- C. Alcohol and/or Drug Abuse Treatment

I understand that Pediatric Associates will not condition treatment on my signing this authorization. Pediatrics Associates will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I understand that, if I refuse to sign this authorization form, it may result in improper diagnosis or treatment, denial of coverage or a claim for benefits, or other insurance or other adverse consequences.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand that I may have a copy of this authorization form by asking Pediatric Associates for one.

To revoke my authorization, I will submit a written request to Medical Records. Unless I revoke this authorization earlier, it will expire one year from the date authorized.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Person Requesting Information

Witness Signature

Signature: _____ Date: _____

Signature: _____ Date: _____

Print Name: _____

Print Name: _____

Relationship: _____