

The information in this authorization is confidential and protected by Federal and State law from unauthorized use of disclosure.

I, _____, hereby authorize
(Parent/Patient Name and Address)**

(Physician, Facility Name and Address)

to release to **Lancaster Pediatric Associates, LTD.** information from the medical record of:

Patient Name: _____

Date of Birth: _____ Social Security # _____

Information to be released:

Complete Records _____ Last two (2) years _____

Specific Dates: _____

I certify that I understand the contents of the form. This consent begins on the date of signature and is valid for a period of 90 days. Pennsylvania law prohibits Lancaster Pediatric Associates, LTD. from making further disclosure of information unless written authorization for further disclosure is expressly permitted from the person to whom it pertains or is otherwise permitted by law. General authorization is not sufficient for this purpose.

****IMPORTANT—Patients fourteen (14) years of age or older treated for mental illness, drug abuse, alcohol abuse, or birth control measures must sign this authorization themselves. Patients eighteen (18) years of age or older must sign for themselves.**

(Parent/Patient signature)

(Relationship to patient)

(Date)

NOTE: Your previous doctor may charge you for these records.