ALL STAR PEDIATRICS
...where every child is a star.

**702 GORDON DRIVE ● EXTON, PENNSYLVANIA 19341**
**(610) 363-1330 ● (610) 524-8574**

**HIPAA COMPLIANT AUTHORIZATION FOR RELEASE/ACCESS OF MEDICAL INFORMATION TO A THIRD PARTY**

The medical records cannot be released until this form is completed and signed by the patient (if at least 18 years old) or parent or legal guardian (if under 18 years old). ***You must complete this form thoroughly.***

**PLEASE PRINT**

**Step 1**: Patient Name: _____ Date of Birth: _____

**Step 2**: I hereby authorize All Star Pediatrics_____ to release my health information **TO**:

Name of Authorized Person/Entity_____

**Step 3: I am authorizing access to the following areas of information:**

- **Immunizations**
- **Medication List**
- **Growth Chart**
- **Problem List/Diagnosis List**
- **All Hospital/Urgent Care/ER Records**
- **Psychiatry/Psychology/Mental Health Records**
- **Colonoscopy**
- **All Imaging**
- **Lab Results**
- **Progress Notes**
- **All Consults**
- **All Chart Messages**

**PLEASE INITIAL BELOW TO INCLUDE THE FOLLOWING:**

_____ALCOHOL/DRUG TREATMENT

_____MENTAL HEALTH INFORMATION

_____HIV-RELATED INFORMATION

_____GENETIC TESTING

**Step 4: Purpose for disclosure is at the request of the individual based on the following:**

_____ Continuity of Care

Other Reason: _____

_____Providing access to records to another Individual who is not the patient/guardian

_____

**Step 5: CONDITIONS OF AUTHORIZATION**

I have the right to revoke this authorization at any time by writing to the Privacy Officer at All Star Pediatrics at the above address and revoking my permission. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I understand that signing this form is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations.

This authorization is **valid for 365 days** for the release of information as indicated by date of signature below.

_____ _____

*Patient/Guardian Signature & Date*

*If not the patient, name and authority to sign on their behalf & Date*