Tri-County PEDIATRICS

Release of Medical Information

I hereby request and authorize Tri-County Pediatrics, Inc. to use and disclose protected health information ("(PHI)") for the following child(ren) listed below:

Patient's Full Name:_____Patient's Date of Birth: _____

Patient's Full Name:_____Patient's Date of Birth: _____

Home Phone #_____Cell or Other Phone _____

Current Address_____City/State/Zip_____

This Authorization applies to the following date(s) of service:_____

❒ Complete Medical Records
❒ Chart Notes
❒ Immunizations Only
❒ Other: (specify)

❒ Consultation Notes
❒ Patient Summary of all visits
❒ Radiology/ EKG/ Lab Reports

Medical Records Fee must be paid before the records are printed. These charges apply only if Tri-County Pediatrics, Inc. is releasing the records.

Reason for Request to Release Complete Medical Records:
❒ Review by Specialist, Surgeon, or Therapist ❒ Moving From Area ❒ Other (Please specify):

Please release the requested records:
From To

Tri-County Pediatrics, Inc.
❒ **Chalfont** – 140 E.Butler Ave, Chalfont , PA 18914
Tel: 215.822.1770 Fax: 215.822.5232
❒ **Elkins Park** – 1939 Cheltenham Ave, Elkins Park, PA 19027
Tel: 218.884.5715 Fax: 215.884.1442
❒ **Northeast Philadelphia** – 9121 Roosevelt Blvd. Philadelphia, PA 19114 Tel: 215.676.5577 Fax: 215.676.2485
❒ **Huntingdon Valley** - 821 Huntingdon Pike, Suite 207, Huntingdon Valley, PA 19006 Tel: 215.379.3022 Fax: 215.379.3025
❒ **Southampton** - 729 Grove Avenue, Suite 1, Southampton, PA 18966 Tel: 215.322.0800 Fax: 215.322.2073
❒ **Warminster** - 205 Newtown Road, Suite 210, Warminster, PA 18974 Tel: 215.672.7272 Fax: 215.672.7042

From To

Practice Name _____
And Address:
_____
_____

Phone:_____Fax:_____

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date(s) of service indicated, and for the purpose written above. Tri-County Pediatrics Inc. shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

_____ _____ _____
Signature of Patient or Legal Guardian Printed Name of Signing Party Date

Date: Initials:
Sent via: Picked-up , Mailed or Faxed
Fee Paid: Cash, Check or Credit Card
Fee Amount:

Relationship to patient_____if relationship is other than parent, documentation of legal authorization(s) or Guardianship must be attached.