Pediatric Care Specialists / Behavioral Health Services
1322 Eisenhower Boulevard
Johnstown, PA 15904
(814) 266-8840 (814) 266-8863 fax

Patient Authorization to Release Health Information

Patient Name ______________________________ DOB _________ Phone#___________________

Address _____________________________________City_____________ State/Zip___________

Release From____

Address _________________________________City ________________ State/Zip ____________

Phone Number __________________________________ Fax Number ________________________

Send To ____

Address __________________________________ City ______________State/Zip_____________

Phone Number _________________________ Fax Number ________________________________

Authorization for release by means of: ☐ Verbal ☐ Mail ☐ Fax

Reason for release: ☐ Continuation of Care ☐ Insurance ☐ Self ☐Family

☐ Other (specify) ____

No fee for the following: ☐ Office Visits (up to 1 yr) ☐ Growth Chart ☐ Vaccine Records

Fees Charged For: ☐ Office Visits (under 1 yr) ☐ Reports/Consultations ☐ ER Visits

☐ Specify Other: ____

☐ Medical History ☐ Treatment or Tests ☐ Hospital Records ☐ Consultations

☐ Prescriptions ☐ School Records ☐ Psychological Reports/Evaluations

☐ Psychological Therapy Progress Notes ☐ Psychological Therapy Attendance Records

☐ Psychological Treatment Plan ☐ Psychiatric Evaluations

☐ Verbal Communication w/ Agencies ☐ Sensitive Material (HIV, Substance Abuse or Exposure)

Signature____ Date__________________________

1. Unless otherwise revoked, this authorization will expire 1 year from the date of signature.
2. I understand that once this information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and is therefore not protected by federal privacy regulations.
3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company/attorney requests when the law provides my insurance the right to contest a claim under my policy.
4. I understand that I need not sign this form in order to ensure health care treatment/payment/operations.
5. I understand that if I have questions about disclosure of my child's health information, or want a copy of this authorization, I may contact the Privacy Officer here at Pediatric Care Specialists at the address listed above.

I authorize the release of my child's information and I understand that I can not hold PCS / BHS responsible for information released at my request.

Signature____Date________

Witness____Date________