



Authorization for Release of Protected Health Information

Authorization to release my PHI is hereby granted to:

Name of Facility or Physician

Address City St Zip

Telephone Number Fax Number

Records are requested for the purpose of (Provide a Detailed Description): _____

Medical Records being released to:

First Steps Pediatrics & Adolescent Medicine, P.L.L.C.

Three Robinson Plaza, Suite 100

Route 60 & Park Manor Drive

Pittsburgh, PA 15205

Phone: (412)788-1999 Fax: (412)294-5103

Information regarding the patient named below:

Name

Address City St Zip

Date of Birth Social Security Number / MR#

Please Include The Following: _____ Dates From: _____ to: _____

| | | | | | |
|-----------------------|--------------------------|-------------------|--------------------------|--------------------------|--------------------------|
| All Records* | <input type="checkbox"/> | Discharge Summary | <input type="checkbox"/> | Growth Charts | <input type="checkbox"/> |
| Lab Findings | <input type="checkbox"/> | Office Notes | <input type="checkbox"/> | History & Physical Notes | <input type="checkbox"/> |
| Other Diagnostic test | <input type="checkbox"/> | X-Rays | <input type="checkbox"/> | Surgeries & Procedures | <input type="checkbox"/> |
| Pap Results | <input type="checkbox"/> | Immunizations | <input type="checkbox"/> | *Justification | <input type="checkbox"/> |

HIV, BEHAVIORAL HEALTH AND SUBSTANCE ABUSE INFORMATION CONTAINED IN THESE RECORDS WILL BE RELEASED THROUGH THIS AUTHORIZATION UNLESS OTHERWISE INDICATED BELOW:

DO NOT RELEASE: HIV SUBSTANCE ABUSE BEHAVIORAL HEALTH/PSYCHIATRIC OTHER

I understand the following:

* That my health records will not be released or obtained by FSP unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information.

*That the release of my health records will be for the purpose stated on this form, and only those items checked off will be released.

*That the Authorization is in effect for a period of 365 days unless a specific timeframe less than one year is documented.

*That I have the right to revoke this Authorization form at any time by sending a written request to the above listed facility/physician.

My decision to revoke the Authorization does not apply to any release of my health records that may have taken place prior to the date of my request to revoke and may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.

* I am entitled to a copy of this completed Authorization form.

Signed _____ Date: _____

(Parent Guardian Self)