Lancaster Pediatric Associates, Ltd.

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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* **Home Address**

_____
(Physician, Facility Name & Address)

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

Patient Name: _____

Date of Birth: _____

Medical Information to be released:

Complete Records _____ Last two (2) years _____

Specific Records/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.

_____ _____
(Parent/Patient Signature) **(Relationship to Patient)**

_____
(Date)

Please note, you may be charged a fee from the Physician/Facility releasing your medical records.

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