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_____

Print Name_____ Relationship to patient_____

Witness_____Date_____