Torresdale Pediatrics Tel: 215-638-0555 Fax 215-638-2929 www.tpeds.com

Torresdale Pediatrics Record Release Form

Child Identifier	Child's Full Name	Child's Date of Birth
1		
2		
3		
4		

Primary Address:_____

Patient Phone: (___)_____

I hereby authorize the release of all information in my child(ren)'s medical record from Torresdale Pediatrics, 2217 Bristol Pike, Bensalem PA 19020 _____
Check for each child by identifier number above: ( ) 1 ( ) 2 ( ) 3 ( ) 4

This includes contents regarding drug and alcohol abuse, psychiatric, psychotherapy notes and HIV related diagnosis and/or test results.
Check for each child by identifier above: ( ) 1 ( ) 2 ( ) 3 ( ) 4

Information is to be released to:

_____

_____

Restrictions/Duration/Rights

Initials	Authorization to Release Medical Information
	I authorize the release of all information from my children's medical records unless otherwise specified.
	I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
	I understand that I may be charged for copying costs.
	This authorization may be revoked at any time. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization is valid.
	This authorization expires 6 months after the date of signature, or as specified: _____
	I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.
	A photocopy of this release is as effective as the original.
	I have received a copy of this authorization

Signature: _____ Date: _____

If signed by other that the patient, indicate relationship: _____

Witness (Print Name): _____ Signature: _____