8080 Old York Road, Suite 207, Elkins Park PA 19027
Tel: 215-935-6493
Fax: 215-935-6964
www.lifestagespeds.com

Lifestages Pediatrics LLC

Authorization for Release of Medical Information

Patient Name: _____ DOB: ___/___/___

I, _____hereby authorize the release of medical information

TO: Lifestages Pediatrics
8080 Old York Road, Suite 207
Phone: 215- 935-6493
Fax: 215 -935 6964

From: Doctor/Clinic/Hospital: _____
Address: _____
Address: _____
Phone: _____
Fax: _____

Please release the following:

__ All health information (including growth charts and vaccination records)

__ History/Physical Exam
__ Discharge Summaries
__ Progress Notes
__ Consultation Reports
__ Radiology/ Images
__ Diagnostic Test Results
__ Lab Results
__ Pathology Reports
__ Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

__ Yes, I consent to the release of this information.
__ No, I do not consent to the release of this information.

Purpose of disclosure:

__ Treatment/ Continuing medical care
__ Change of Physician
__ Personal use
__ Attorney/Legal
__ Change of Insurance Please specify your new carrier _____
__ Other _____

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____