121 JPM ROAD
LEWISBURG, PA 17837
TEL: 570-551-0300

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ____

DOB: ________________________________

I, ____ hereby authorize the release of medical information

TO:
MARY BETH O'HARA, D.O., F.A.A.P.
IDEAL PEDIATRIC AND ADOLESCENT CARE, P.C.
121 JPM ROAD, LEWISBURG, PA 17837

FROM:
Doctor/Hospital/Clinic: ____

Address: ____

____

Telephone: _______________________ Fax: __________________________

Please release the following:
___All Health information (including growth charts and immunizations) ___Labs and Radiology
___History and Physical Exams
___Progress Notes ___Consultation Reports
___Consultation Reports ___Other

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 or drug abuse with 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

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

Signature: _______________________________________

Date:____________________________

Printed Name: ___________________________________ Relationship to Patient: ______________