Patient Name (First, Middle, Last)		Date of Birth
Address	City/State/Zip Code	Telephone Number

I am requesting my protected health information (PHI) from: ◯ Pediatric Care Specialists (PCS) ◯ Behavioral Health Services (BHS) ◯ Vision Care Specialists (VCS) ◯ Other ____

Address: ____ **Phone #** ____________________

Fax # ____________________

I request my PHI be released to:
◯ PCS ◯ BHS ◯ VCS at **1322 Eisenhower Blvd., Johnstown, PA 15904 or by fax to 814-266-8863**
◯ Other Person or Institution: ________________________ Address: ______________________________

City: ____________________ State: __________ Zip Code: ____________ Fax (if HealthCare Provider) ______________

Special Records: I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check appropriate box(es) below:

AIDS/HIV Information	**Psychiatric Care/Treatment**	**Drug or Alcohol Abuse Treatment**
◯ Yes, disclose	◯ Yes, disclose	◯ Yes, disclose
◯ No, do not disclose	◯ No, do not disclose	◯ No, do not disclose

I authorize the following PHI to be released from my medical records:

☐ Discharge Summary/Instructions	☐ Operative Report	☐ Lab Records	☐ Radiology Images/Reports
☐ Prescriptions	☐ ER Record	☐ EKG/ECG Cardiac Tests	☐ Abstract (Significant Documents)
☐ History and Physical	☐ Medical History	☐ Clinical Notes	☐ Itemized Billing Record
☐ Consultations	☐ Medication Records	☐ Radiology Reports	☐ Immunization Records
☐ Growth Charts	☐ School Records	☐ Psychiatric Evals	☐ Psychological Reports/Evals

☐ Psychological Therapy Progress Notes ☐ Psychological Treatment Plans ☐ Psychological Therapy Attendance

☐ Other Instructions/Records: ____

Covering the period(s) of care from (list applicable dates of treatment): _____/_____/_____ to _____/_____/_____

Purpose of requested Information:
☐ **Legal** ☐ **Insurance**
☐ **Personal** ☐ **Continuation of Care**
☐ Other ________________________________

Delivery Method:
☐ **CD/USB** ☐ **Fax** ☐ **US Mail**
☐ **Verbal** ☐ **Email:** ______________________________

Important: I understand that faxing is not encrypted and may be accessible to others. I also understand that it may be misdirected and easily forwarded to unintended recipients. By choosing this method, I am accepting these risks. **X** __________ **INITIAL**

ACKNOWLEDGEMENT

I understand by signing this record release that I may be charged a fee according to federal law 45 CFR164.524(c)(4) and/or PA Dept. of Health regulation **42** Pa.C.S. §§ **6152**, 6152.1 and 6155 permitting a covered entity to charge a reasonable, cost-based fee that covers labor, supplies and postage associated with providing a copy of your PHI. If a fee applies, our office will inform you and payment is due prior to sending the records. I know I am entitled to a breakdown of cost upon request. *There is no charge for office visits up to 1 year, growth charts and immunization records or when we send records to another physician directly.* **To avoid these fees, you can get most information from our patient portal. X** __________ **INITIAL**

AUTHORIZATION

I hereby authorize Pediatric Care Specialists/Behavioral Health Services/Vision Care Specialists to disclose the health information as described above. I understand that my authorization will automatically expire one year (365 days) after the date of signature on this form. I understand that I may 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 information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law. My refusal to sign this authorization will not affect my ability to received treatment. By signing this form, I understand that I am authorizing Pediatric Care Specialists/Behavioral Health Services/Vision Care Specialists to release information as described above.

X____
Signature of Patient or Personal Representative | Print Name | Date

X____
Relationship of Personal Representative to Patient | Date

If Authorization is signed by someone other than the patient, please state reason **X**________________________________