AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Date: _____

To: _____

_____ _____
Patient Name Date of Birth

_____
Address

_____
City, State, Zip

I, _____, hereby authorize and request that _____ **(NAME OF HEALTH CARE PROVIDER),** release to Martha Bardsley, M.D., LLC d/b/a Bardsley Pediatric and Adolescent Endocrinology**,**. the above-named patient's medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans. I understand that this authorization will expire when this request is fulfilled and that it may be revoked at any time in writing. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient or third parties and no longer protected by the HIPAA privacy rule.

I acknowledge that my records may include sensitive material. Therefore, I request that you include the following records, if any (initial by categories to be <u>included</u> in records provided):

___Substance Abuse ___AIDS/HIV/STDs ___Psychological/Psychiatric Conditions ___Genetic Testing

Please send the requested information to:

Phone: 610-601-3031 **FAX: 610-910-4373**

Bardsley Pediatric and Adolescent Endocrinology
822 Montgomery Ave, Suite 205
Narberth PA 19072

_____ _____
Signature of Patient or Legal Guardian Date

Relationship to patient: _____