Community Services for Children, Inc.
Head Start/Early Head Start of the Lehigh Valley/Pre-K Counts
1520 Hanover Avenue
Allentown, PA 18109
Fax: 610-820-6841

MEDICAL INFORMATION RELEASE FORM

Patient Name (Print Clearly): **Nombre del Paciente (Imprima)**	**Date of Birth:** **Fecha de Nacimiento:**
Patient Address: **Dirección del Paciente:**	**Phone Number:** **Número de Teléfono:**

I authorize: Autorizo a:
Location(s) of Care (Name of medical or dental office/clinic/agency)

Address/Dirección:			
Phone /Teléfono:		**Fax Number:**	

To release my Medical Records as indicated below to: Community Services for Children - 1520 Hanover Avenue, Allentown, PA 18109 - Attn: Health Services Department for the purpose of determining my/my child's health status as required by the Federal Mandate governing Head Start/Early Head Start Programs.

Information Requested (check all that apply)

- ❑ Most Recent well child exam, immunization record, hearing, vision, tuberculin, lead and anemia test results, medical conditions, allergies and medications
  - ❑ Include records as stated in line above for dates of service ______________________ to ________________________
- ❑ Birth Record
- ❑ Dental Report
- ❑ Prenatal records (including initial pregnancy profile, risk assessment, labs, ultrasounds, history,) for the dates of service _____________ to ______________
- ❑ Postpartum appointment including birth delivery record
- ❑ Other: ____
- ❑ **Exception: I do not give permission to release (please specify)** _____________________________________

ATTENTION PATIENT: IF APPLICABLE, PLEASE COMPLETE THIS SECTION

I understand that my medical record may contain "protected" information related to these categories. My signature next to these items acknowledges my awareness and my authorization to release this "protected" information.

_______________ **Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician (Confidential Alcohol and Drug Abuse Patient Information, 42 C.F.R. Part II)**

_______________ **Psychiatric or psychological information, if psychiatric or psychological treatment was given by physician (PA Mental Health Procedure Act).**

_______________ **HIV related information, if HIV-related tests were ordered by my physician (Confidentiality of HIV-Related Information Act, PA Law Act 148).**

Information is being disclosed from records whose confidentiality is protected by Federal Law [42 C.F.R. Part II] and PA State Statutes [Title 55PA Code 5100.32 and 5100.34(a) & (b) and DAACA, 71 P.S. 1690.108(b) & (c)].

- ✓ I understand that my authorization will remain effective for a period of 90 days from the date of my request.
- ✓ I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it is given unless revoked by me.
- ✓ I understand that the provider may not hinder treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- ✓ I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

Date Consent Expires: ________________________

Patient Signature: ________________________ **Print Name** ________________________________ **Date Signed**:_____________

Signature Authorized Representative: **X**__________________________ **Print Name**: **X**____________________ **Date: X** ____________

Relationship to Patient: **X**______________________________

Is the patient a minor? ❑Yes ❑No	**If yes, are there any legal restrictions of your authority to act on behalf of the minor? ❑Yes ❑No If yes, attach a copy of the appropriate legal document, which proves authority to act on behalf of patient.**

Witness signature
(CSC staff): X____________________________ **Printed Witness Name**: **X**_______________________Date Signed: **X**__________

Caseload/Center: Initial Records Request? ❑ Yes ❑No If yes, date enrolled _______________