pennsylvania
DEPARTMENT OF HEALTH

COMMONWEALTH OF PENNYLVANIA
DEPARTMENT OF HEALTH

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize the Pennsylvania Department of Health to release information in its files relating to treatment and services provided to:

_____

(*name of person/minor **and** date of birth)

☐ Records pertaining to: _____

☐ Records from: _____ to _____

The records should be sent to:

_____

(name of person or agency to whom records are to be released)

_____

(address of person or agency to whom records are to be released)

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

PRINT NAME: _____

ADDRESS: _____

**DATE: _____

*If the request for release of records involves the records of a minor or an individual that is not yourself, please state your relationship to the patient, such as parent or guardian of the minor. If the release of records involves a minor, a birth certificate or other such documentation indicating legal parentage/guardianship is required for the release of records. Further, if the release of records involves a decedent or otherwise incapacitated person, a power of attorney, administrator of an estate, or other such legal documentation stating that the person signing this form on the behalf of someone else is legally authorized to do so, is required to accompany this form for the release of records.

**This authorization expires one year after the date it was executed.