Authorization for Release of Health Information

1247 S. Cedar Crest Blvd, Suite 101 • Allentown, PA 18103
610-770-1800 • www.everychildeverytime.com

EFFECTIVE MARCH 19, 2018: Medical Records may be requested by and released ONLY to the Parent/Guardian of the patient (patients under 14 years of age), or to the patient directly (patients 14 years or older). CICS will no longer directly release records to outside entities including schools, medical offices or employers except under limited circumstances and with the prior permission of the parent/guardian and/or patient.

REQUEST FOR RECORDS

Please complete this Authorization in its entirety. Incomplete forms may delay timely processing and/or may be returned to the patient for additional information.

I _____ hereby request Children's Integrated Center for
(Name of Parent/Guardian/ Patient)
Success (CICS) to release medical/behavioral health information from the records of:

Patient Name:	
Patient Date of Birth:	

Please specify what information is being requested:

	Discharge Summary		Psychological Testing Results (WISC/WIATT)
	Diagnosis Letter ($20.00 flat fee after regroup)		ADOS Summary
	Lab Reports		Quotient Testing Results
	Medication Summary of Treatment		Genetic Testing Results*
	Psychiatric/ Psychological Evaluation Summary		Other (Specify):
	Occupational / Speech Evaluations		
	Counseling: Summary of Treatment		

***IMPORTANT NOTE ON THE RELEASE OF GENETIC TESTING RESULTS:**

CICS values the use of genetic testing in diagnosis, treatment, and providing informed care for each patient. The information contained in these reports is highly sensitive and should be handled with care. While Parents/Guardians and Patients (14 yrs+) may request copies of these materials it is **STRONGLY** recommended that these reports be handled with appropriate confidentiality. Due to the sensitive information contained within these reports CICS **WILL NOT** release genetic testing results prior to reviewing these materials with parents/ guardians and/or patients.

RESPONSIBLE PARTY:

Please complete the following information for the Parent/Guardian and/or Patient to whom records will be released:

Name of Parent/Guardian or Patient (14yrs+): _____

Address: _____

_____

Phone: _____ **Fax**: _____

Email: _____

How would you like to receive the requested information? (Please circle):

Fax	Email	Mail	Verbal Communication	Will pick up from CICS

RECORDS RELEASE DISCLOSURE: Please initial each item below and sign to complete this request.

	This authorization allows for the release of information that exists in the patient's medical record as of the date of signing, as well as information created for up to one (1) year after signing. This authorization will expire in one (1) year unless a shorter timeframe is indicated below. Patients (14 years of age or older), or parent(s)/ guardian(s) may revoke consent in writing at any time. Authorization is valid from: _____ to _____ (not to exceed one (1) year from signature)
	Released information will no longer be protected by CICS Privacy Practices. CICS and its staff/ employees are not to be held responsible or liable as a result of re-disclosure of this information on the part of the Responsible Parties listed above.
	In accordance with PA state law, **CICS is authorized to charge a fee for the reproduction of medical records**. This fee may not exceed $0.75/page.
	Every effort will be made to process medical records requests in a timely manner however in some situations it may take up to 30 days. Per PA state law, CICS will notify you in writing if there will be a delay in the processing of this request beyond 30 days, or if this request is denied/ cannot be fulfilled for any reason.
	In some cases records may not be released without prior review of materials with a CICS Provider.

Patient/ Parent/ Guardian signature indicates that this document has been reviewed, conditions have been approved, and consent is given to release the above indicated information.

Printed Name of Requestor: Signature Date
Parent/ Legal Guardian/Patient (14 years and older)

Printed Name of Witness Signature Date

Medical Records Policies

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Effective March 19, 2018

Who May Request/ Receive Medical Records?:

- Medical Records may be requested by and released **ONLY** to the Parent(s)/Guardian(s) of the patient (patients under 14 years of age), or to the patient directly (patients 14 years or older). **CICS will no longer directly release records to outside entities including schools, medical offices or employers except under limited circumstances and with the prior permission of the parent/guardian and/or patient.**

- Parent(s)/Guardian(s) or Patients wishing to share medical and/or academic records from other providers, schools or outside organizations with CICS must contact these entities directly to request records be sent to CICS. Records may be faxed to 610-770-1805, Attention: Medical Records.

- It is the Parent(s)/Guardian(s) responsibility to make CICS aware of any court orders, custody and/or guardianship agreements that would affect, limit or prohibit distribution or disclosure of medical information.

- CICS is obligated to release medical records upon the request of Insurance Companies for purposes of billing claims, securing prior authorization and/or to determine medical necessity of services. CICS will also release records per the request of State or Local Agencies (i.e. Children and Youth, Department of Disability, etc.) and per court-orders as appropriate and in accordance with state and local laws.

Process to Release Medical Records:

- It is **REQUIRED** that Parent(s)/Guardian(s) and/or Patients complete a "regroup" meeting with a CICS Provider to review all records, tests, evaluations and results prior to receiving medical records. The release of medical records prior to a professional consultation may result in inaccurate or miscommunicated diagnosis by those receiving these records. Parent(s)/Guardian(s) and/or Patients wishing to receive medical records absent a professional consultation must sign an additional disclosure statement acknowledging these risks prior to receiving records and may be discharged from the practice as a result.

- Due to the sensitive and confidential nature of genetic testing results these records will **NOT** be released prior to a full review of this information with a CICS Provider.

- In accordance with PA State Law protecting Mental Health Records, psychotherapy notes **WILL NOT** be released without a court-order.

- Parent(s)/Guardian(s) and/or Patient(s) (14 years and older) who wish to receive physical copies of medical records who have already discussed results of records with a CICS Provider (i.e. "regroup") must complete and sign an "Authorization for Release of Health Information" which is valid for one-year unless a shorter timeframe is designated.

- Every effort will be made to process medical records requests in a timely manner however in some situations it may take up to 30 days. Per PA state law, CICS will notify you in writing if there will be a delay in the processing of this request beyond 30 days, or if this request cannot be fulfilled.

Fees to Process Medical Records:

- Copies of medical records will be provided to Parent(s)/Guardian(s) and/or Patients at no cost during the final "regroup" appointment and/or during pre-determined follow-up visits to discuss test results. In accordance with PA state law, CICS is authorized to charge a fee for any additional copies of medical records requested outside of these appointments. This fee may not exceed $0.75/page.

- Diagnosis Letters will be created upon request **after** parent regroup for a flat fee of $20.00.

- Diagnosis Letters that include school-based recommendations/ accommodations will be created upon request **after** parent regroup for a flat-fee of $50.00.

Permission for Verbal Communication:

- Patients 14 years and older must sign a "Permission to Communicate" form in order for CICS Providers to discuss the patient's medical records, including diagnoses, test results, treatment, progress, and recommendations with parent(s)/guardian(s) and any outside entities.

- Parent(s)/Guardian(s) and/or Patient(s) (14 years and older) must complete a "Permission to Communicate" form to authorize CICS Providers to discuss (verbally or via written correspondence) relevant medical information, including but not limited to psychiatric/psychological evaluations, and counseling sessions/progress, with outside entities (i.e. schools, other medical providers).

Permission to Communicate

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Please complete this Authorization in its entirety. Incomplete forms may delay timely processing and/or may be returned to the patient for additional information.

The intention of this form is for Parent(s)/Guardian(s) and Patients (over 14 years of age) to authorize verbal and/or written communication between CICS Providers and outside entities as appropriate for the continued care of the patient.

I hereby authorize Children's Integrated Center for Success (CICS) to release, obtain, or exchange medical/behavioral health information from the records of:

Patient Name:	
Patient Date of Birth:	
Patient Address:	
Patient Phone:	

This authorization is valid only for the release or exchange of information with the following:

Name of Person or Entity:	
Address:	
Phone:	
Fax:	
Email:	
Relationship to Patient:	Parent/ Guardian Medical Professional School Employer Other:

Please specify how you would like information to be shared:

Verbal	**Written**
i.e. phone conversations, in-person, etc.	i.e. email, summary letters, etc.

Communications Disclosure:

- This authorization allows for the disclosure – via verbal and/or written communication - of information that exists in the patient's medical record as of the date of signing, as well as information created for up to one (1) year after signing. This authorization will expire in one (1) year unless a shorter timeframe is indicated below. Patients (14 years of age or older), or parent(s)/ guardian(s) may revoke consent in writing at any time.

  Authorization is valid from: _____ to _____ (not to exceed one (1) year from signature)

Patient/ Parent/ Guardian signature indicates that this document has been reviewed, conditions have been approved, and consent is given to communicate regarding the patient's medical records as indicated.

Printed Name of Patient	Signature (***if 14 year and older***)	Date
Printed Name of Parent/ Legal Guardian	Signature	Date
Printed Name of Witness	Signature	Date