Healing Hands for ADHD
Linda Caballero-Goehringer, M.D.
3512 State Route 257, Suite 107
814-670-0260
814-253-2600

Medical Record Release Form

Facility/Provider: _____
Address: _____
Phone: _____Fax: _____

By Signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician, person, facility, or entity listed below on today's date: _____

Patient Name: _____ Date of Birth _____

The information that may be released subject to this signed release is as follows:

We will need the last two physicals, any behavioral evaluations, any visits regarding this diagnosis. Any referrals regarding academic or educational difficulties. A list of all patient's medications given in order. Any hospitalizations for mental health. Any care plans, progress notes and treatment records pertaining to this diagnosis.

Release my protected health information to the following physician/person/facility and/or those directly associated with my medical care: **Healing Hands for ADHD**
Linda Caballero-Goehringer, M.D.
3512 State Route 257. Suite 107
Seneca, PA 16346
814-670-0260
814-253-2600

The Purpose/reason for this release of information is as follows:
_____

I understand that this Authorization is effective for 365 days from the date of the signature, unless otherwise specified below. No time frame may exceed 1 year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information.

Date: _____ Signature of Patient: _____
(If the patient is 14 years of age or older, they may authorize the release of mental health information. A minor can authorize release of drug and alcohol treatment information without parental consent.)

Date: _____Signature of Parent/Legal Guardian: _____

Date: _____Witness/Staff Member: _____

*Authorized Representative's relationship and authority to act on behalf of patient: _____

Additional Patient Rights

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items listed will be released.
- Although applicable law may prohibit redisclosure of these records, I understand that the facility/person that receives them may re-disclose the information.
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- Healing Hands for ADHD cannot require me to sign the Authorization in order to receive treatment.
- I am entitled to a copy of this completed Authorization form.