Lancaster County Youth Intervention Center

235 Circle Avenue
Lancaster, Pennsylvania 17602

Authorization to Release Medical Records

I, _____, **DOB:** _____
(Patient's Name)

hereby authorize, _____ and _____
(Primary Physician) **(Primary Dentist)**

to release the following information:

(Information Requested)

to Lancaster County Youth Intervention Center, PrimeCare Medical Services, or an authorized representative for the purpose of rending medical and psychological diagnosis and treatment. I understand that the confidentiality of the disclosed information is protected from further disclosure without my prior written consent and I understand that I have no obligation to permit the disclosure or release of this information. This consent and authorization are subject to revocation. Revocation may be accomplished by notifying the Youth Intervention Center, PrimeCare Medical Services in writing or by specifying a date, time, event or condition upon which this consent will expire. I also authorize Lancaster County Youth Intervention Center, PrimeCare Medical Services to photocopy the original of this consent and authorization and to provide a photocopy to the disclosing or releasing institution or person.

I certify that I have read this form or had it read and explained to me and that I understand its provision.

_____ _____
Name of Child **Signature of Child**

_____ _____
Name of Parent or Guardian (Please Print) **Signature of Parent or Guardian**

_____ _____
Name of Witness (Please Print) **Signature of Witness**

_____
Date

Medical Office Use Only

(To be mailed to Parent/Guardian/Custodian if not completed within 10 days.)

_____ _____
Date Mailed Medical Staff Signature

_____ _____
Name of Parent/Guardian/Custodian Street Address

_____
City, State, and Zip Code