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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ _____
Patient's Full Name Patient's Date of Birth

_____ _____
Steet Address City, State, Zip Code

_____ _____
Home Phone Number Cell/Work Phone Number

I, _____, do hereby authorize PEDIATRIC WELLNESS OF NNY to use/disclose the medical records of the above-named individual to the facility and/or individual specified below.

PLEASE MARK ALL THAT APPLY
( ) ALL MEDICAL RECORDS ( ) IMMUNIZATION RECORDS ( ) OTHER _____
( ) I DO authorize release of information related to AIDS (acquired Immunodeficiency Syndrome) or HIV (Human
( ) I DO NOT Immunodeficiency Virus) infection, psychiatric care, and treatment and/or drug abuse.

Release to / Obtain from:
PLEASE CIRCLE ONE

_____
Name of Individual/Facility

_____
Address

_____
City, State, Zip Code

PURPOSE OF DISCLOSURE: ( ) CHANGE OF PROVIDER ( ) SWITCHING TO ADULT PHYSICIAN ( ) MOVING OUT OF THE AREA
( ) PERSONAL ( ) OTHER PLEASE SPECIFY:_____

FOR PERSONAL USE THERE WILL BE A CHARGE OF $5.00 PER DISK PLUS POSTAGE

I hereby authorize the use and disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to by the person or class of person or facility receiving it and would no longer be protected by federal regulation. I understand that the medical provider whom this is authorized may not condition its treatment of me on whether or not I sign the authorization.

_____ _____ _____
Signature of Patient/parent/legal guardian Relationship to Patient Date

_____ _____
Witness Date