Authorization to Receive Protected Health Information

(Please make sure all blanks are filled in; failure to do so may prevent or delay release of information.)

This authorization may include the disclosure of information relating to Alcohol and Drug Abuse and/or Mental Health Treatment unless I indicate otherwise. This authorization hereby permits the release of my protected health information

FROM: _____**PHONE #** _____
(PLEASE PRINT)

ADDRESS:_____ **FAX #**_____
(PLEASE PRINT)

Regarding Patient Name:_____**DOB**:_____
(PLEASE PRINT)

TO: (Circle one)

Glens Falls Pediatric Consultants PC
1 Lawrence Street, PO Box 141 Glens Falls NY 12801
Phone: (518)798-9985Fax: (518) 761-7043

Pediatric Associates of Saratoga
4 Carpenter Lane, Saratoga Springs NY 12866
Phone: (518)587-3823Fax: (518)761-7043

Information to be released:

___AllMedicalRecords (excluding HIV information) or all records specific to dates from _____ to _____.
____ Office Visit progress notes (Dates to/from)_____ ____Lab Data ____ EKG and Cardiac reports
____History and Physical (Dates to/from)_____ ____Discharge Summary ____Operative Notes/Pathology
____Immunization Records ____X-Ray reports (if actual films are needed, please contact Radiology where they were taken.)
____Other:_____

*****If medical record contains any HIV information, a separate release is required to be signed*****

(PLEASE PRINT)**Reason for release (optional):**

Comments:_____

_____

Disclosure: I understand that this authorization may be revoked in writing by me at any time and that it will automatically expire one (1) year after the date of signature. Glens Falls Pediatric Consultants, PC/Pediatric Associates of Saratoga is not legally responsible for any disclosure that may arise from requested information.

Signature of patient/legal representative:_____**Date:**_____

Relationship if not signed by the patient_____

****Any patient over the age of 18 years of age must sign for the release of their records; parent's signature cannot be accepted**

Practice Witness:_____ **Date:**_____