

**Glens Falls Pediatric Consultants, PC
Pediatric Associates of Saratoga
Release of Information and HIPPA statement for a patient at least 18 Years of Age**

Patient Name

Date of Birth

I authorize the staff at Glens Falls Pediatrics Consultants and Pediatric Associates of Saratoga to release all office visit and health information regarding my care and treatment to the following person(s):

Parents or Legal Guardians Only (names) _____,

Relationship to the patient _____,

Relationship to the patient _____,

I am at least 18 years of age and do **NOT** give permission for the staff at Glens Falls Pediatrics and Pediatric Associates of Saratoga to release information regarding my office visit and health information concerning my care and treatment to anyone.

How would you like us to communicate (please check all that apply)

Appointment Information

On home phone
On cell phone
On office phone
With family member
Via email

Medical Information

On home phone
On cell phone
On office phone
With family member
Via email

This consent shall remain in effect until revoked in writing.

Patient Signature

Date

Please provide a contact phone number for yourself as a patient: _____

Witness

Date