Glens Falls Pediatric Consultants, PC
Pediatric Associates of Saratoga
Release of Information and HIPAA 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):

☐

______________________________ Relationship to the patient __________________________,

______________________________ 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		**Medical Information**	
On home phone	☐#_____________	On home phone	☐#_________________
On cell phone	☐#_____________	On cell phone	☐#_________________
On office phone	☐#_____________	On office phone	☐#_________________
With family member	☐#_____________	With family member	☐#_________________
Via email	☐_____________	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

Updated 03.23