Glens Falls Pediatric Consultants PC
154 Warren St., Glens Falls NY 12801
Phone: (518) 798-9985
Fax: (518) 761-7043

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

Authorization for Release of 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 Glens Falls Pediatric Consultants, PC/Pediatric Associates of Saratoga to release the health information regarding:

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

TO:

Office name: _____

Address: _____

Office Phone number: _____ **Office Fax**:_____

Information to be released:

____ All Medical Records (excluding HIV information) or all records specific to dates from _____ to _____.
____ Office Visit progress notes (Dates TO/FROM)_____ ____Lab Data ____ EKG/ 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*****

Reason for release:

____Consult-Continued medical care (need to transfer care) ____Consult-Continued medical care (NOT a transfer from practice)
____Legal representation ____Leaving the Practice; indicate reason or comment:
____Moving out of the area ____Insurance change: (type)_____ ____Aged out of Pediatric Care
____Billing issues/concerns ____Dissatisfied with office experience (please contact office manager)
____ Other:_____

Comments:_____

Disclosure: I understand that this authorization may be revoked in writing by me at any time and that it will automatically expire 1year 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. A $0.75 per page charge may apply for certain types of requests.

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:**_____

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Consent For Participation in NYSIIS for Individuals 19 Years of Age or Older

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-2839.

I give my consent for _____ (name of doctor or organization) to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.

The immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in NYSIIS. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.

Print Name

Date of Birth

Signature

Date