

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: _____
(PLEASE PRINT)

ADDRESS: _____ PHONE# _____
(PLEASE PRINT)

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

TO: (Circle one)

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 Ln, Saratoga Springs NY 12866
Phone: (518) 587-3823 Fax: (518) 761-7043

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 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: _____