

**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

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

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

_____ Relationship to the patient _____, PH# _____

_____ Relationship to the patient _____, PH# _____

_____ Relationship to the patient _____, PH# _____

I DO NOT authorize the staff at Glens Falls Pediatrics and Pediatric Associates of Saratoga to release any office visit and/or health care information to anyone.

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

Appointment Information

Medical Information

On home phone # _____

On home phone # _____

On cell phone # _____

On cell phone # _____

With family member # _____

With family member # _____

Are we able to contact you via email YES NO

If yes, please provide your email: _____

This consent shall remain in effect until revoked in writing.

Patient Signature

Date