67 North Main Street, 2nd Floor
New City, NY 10956
Tel: 845-634-8911 Fax: 845-634-9002

kids plus pediatrics PC

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize the release, use, and/or disclosure of the below named individuals' health information as described below:

PATIENT INFORMATION

Name	DOB
Name	DOB
Name	DOB
Name	DOB
Parent Name	Patient Telephone Num:

INFORMATION REQUESTED 75 cents per page payable due at time of request

☐ Immunization Record **ONLY – NO CHARGE**
☐ Summary Paper Copy to include Immunization Record, Growth Chart, and Summary Medical History
☐ Complete Medical Record on Paper
☐ Treatment Information from (date)_____to (date)_____
☐ Specify Other_____

PURPOSE

This information may be disclosed to and used by the following individual or organization for the purpose of:
☐ School ☐ Further Medical Care ☐ Insurance ☐ Personal Use ☐ Legal ☐ Other
TRANSFERRING OUT OF OUR PRACTICE? ☐ Yes ☐ No **IF YES, WHY?**
☐ Insurance Change ☐ Moving ☐ Child's Age ☐ Dissatisfaction with Practice

METHOD OF RELEASE

☐ Fax#_____(only immunization records will be faxed) ☐ Pick up in office
☐ ***INFORMATION REQUESTED as above 75 cents per page due at time of request***
☐ Mail to following **$8 Postage Charge is required**(***all records must be sent via traceable mail.)***
Name of Individual or organization_____
Address_____City/State/Zipcode_____
Phone Number_____/Fax_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition this authorization **will expire automatically six (6) months from the date on which it was signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the office Privacy Official.

Signature of Patient/Parent/Authorized Representative Date

Please note: All patients over 18 years of age must sign and complete their own release authorization form

PROIBITION ON DISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (45 CFR, PART 164) PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IF HELD BY ANOTHER PARY IS NOT SUFFICEINT FOR THIS PURPOSE. FEDERAL REGULATIONS STATE THAT ANY PERSON WHO WRONGFULLY USES OR DISCLOSES HEALTH INFORMATION MAY BE FINED $5000.00 TO $250,000.00 AND/OR MAY BE IMPRISONED FOR ONE TO TEN YEARS.