Northeast Pediatrics & Adolescent Medicine, LLP
10 Graham Road West
Ithaca, New York 14850
(607) 257-2188 Fax (607) 266-7341

Authorization to Disclose Protected Health Information

Patient Name: ______________________________________ Date of Birth: ____________________

Address: ____ Phone Number: __________________

I hereby authorize ____
Name and Address of Previous Physician

____
Phone Number Fax Number

To disclose information from medical records of the above named patient.

TO: ***Northeast Pediatrics & Adolescent Medicine, LLP***
10 Graham Road West
Ithaca, New York 14850-1055

For the following Purpose: ____

For the following dates of service ____

Please check one of the following:

________ Mail completed records _________ Fax completed records

________ Pick up records in office. Please call ___________________ when records are completed.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that I have a 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 Health Information Management 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 any insurer with the right to consent to 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 six months from the date it is 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 secure treatment. I understand that any disclosure of information carrier with the potential for an unauthorized redisclosure and the information may not be protected by privacy laws. If I have questions about this authorization, I can contact the Health Management Department at (607) 257-2188.

____ ______________________
Signature of Patient/Parent/Legal Guardian Date

____
Witness