

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

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**Authorization to Disclose Protected Health Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I hereby authorize **Northeast Pediatrics & Adolescent Medicine, LLP** 10 Graham Road West, Ithaca, New York 14850 to disclose information from medical records of the above named patient.

**TO:** \_\_\_\_\_  
Name of Practice/Physician

\_\_\_\_\_  
Address

For the following Purpose: \_\_\_\_\_

Reason for Leaving Practice: \_\_\_\_\_

For the following dates of service \_\_\_\_\_

Please check one of the following:

\_\_\_\_\_ Mail completed records

\_\_\_\_\_ Pick up records in office. Please call \_\_\_\_\_ when records are completed.

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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