WNY Pediatric ENDOCRINOLOGY

(Please check one)

⬭ **Request to Obtain Records**

⬭ **Release of Information Authorization**

By my signature, I authorize WNY Pediatric Endocrinology to use and/or disclose certain protected health information about:

_____
Patient's Name

_____
Date of Birth

_____
Street Address

_____
City, State, Zip Code

To/From the following recipient:

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Phone Fax

Box *must* be completed

Records to Include: (indicate by *initialing*)

___ Complete medical records

___ Records pertaining to: _____

_____

___ Dates of Service from _____ to _____

Records to Include (indicate by *initialing*)

___ Alcohol/Drug Treatment

___ Mental Health Treatment

___HIV-Related Information

This information will be used for the following purpose: _____

This authorization will expire on: _____

I understand that:

- I will be charged $.75 per page for medical records (includes photocopying fees, postage, and labor) for any copies other than summaries of care and immunization records (which are free).
- I have the right to refuse to sign this authorization. Treatment will not be conditioned on my providing this information.
- Special authorization is needed for release of information regarding drug or alcohol treatment, psychiatric outpatient, or sex related treatment.
- Information used or disclosed pursuant to this authorization may be subject o redisclosure by the recipient and no longer be protected by the Federal HIPAA Privacy Rule.
- I may revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

_____ _____
Print Name Relationship to Patient

_____ _____
Signature Date

7 Evans Street
Batavia, NY 14020
Phone: 585-201-7112
Fax: 585-201-7128