(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

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Fax: 585-201-7128