Delmar Pediatrics, pllc

1220 New Scotland Road, Suite 203
Slingerlands, New York 12159
518-439-CARE
Fax 518-439-2834

Authorization to Release Medical Records

PATIENT NAME: _____ DATE OF BIRTH: _____

I authorize Delmar Pediatrics, PLLC to release my medical information to:

_____ _____
Practice Phone Number

_____ _____
Address Fax Number

_____
City State Zip

Reason for transferring records: _____

INITIALS

I understand that if the person or entity that receives the information is not a health care provider, health plan or other entity covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations; and

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to be treated by Delmar Pediatrics, PLLC,

I understand I may revoke this authorization in writing at any time, except to the extent that Delmar Pediatrics, PLLC has acted in reliance upon this authorization. I further understand that my written revocation must be submitted to the Privacy Officer at Delmar Pediatrics, PLLC 1220 New Scotland Road, Suite 203, Slingerlands, New York 12159.

I understand that this authorization will expire six months after the date of signature or automatically when the records requested on this authorization have been released (whichever occurs first).

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I authorize Delmar Pediatrics to obtain my medical information from:

_____ _____
Practice Phone Number

_____ _____
Address Fax Number

_____
City State Zip

Signed by: _____ _____
Signature of Parent or Legal Guardian Date
(Signature of Patient if 18 years old or older)

_____ _____
Print Name Relationship to Parent

PARENT OR REPRESENTATIVE TO BE PROVIDED WITH A SIGNED <u>COPY</u> OF AUTHORIZATION