Pediatric & Adolescent Medicine, LLP

MEDICAL RECORD REQUEST FORM

Child/ren's full name: _____

Last name *First name* *Date of birth*

_____

Last name *First name* *Date of birth*

To previous pediatrician: _____

_____

_____

By signing this authorization, I authorize the named above pediatric office to release all protected health information (PHI) contained in my child/ren medical records to Pediatric & Adolescent Medicine, LLP

Records to be sent to: *Pediatric & Adolescent Medicine*, *LLP*

☐ 390 West End Avenue
suite 1E
New York NY 10024
Fax: 212-799-8620

☐ 495 Central Park Avenue
suite 305
Scarsdale NY 10583
Fax: 914-725-4553

_____ _____

Signature of Parent / Guardian Relationship to Patient

SPECIFIC UNDERSTANDINGS: I understand that this consent may include disclosure of Alcohol and Drug Abuse records and/or Psychiatric records and/or HIV-related information (indicating that I or my children have had an HIV-related test, or have HIV-related illness or AIDS, or that could indicate that I or my children have been potentially been exposed to HIV.) By signing this authorization form, you authorize the use or disclosure of you protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations. If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have the right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.It is understood that any disclosure is bound by 42 CFR Part 2 governing the confidentiality of alcohol and drug abuse patient records and that redisclosure of alcohol and drug abuse information to a party other than one designated above is forbidden without your additional written authorization.