

**HIPAA AUTHORIZATION FORM TO
RELEASE INFORMATION**



Infants, Children & Adolescents

*Diplomates of the
American Board of Pediatrics*

www.childrensmedgroup.com

LOCATIONS:

104 Fulton Ave.
Poughkeepsie, NY 12603
(845) 452-1700
FAX (845) 452-1752

FISHKILL

HOPEWELL JUNCTION

HYDE PARK

MODENA

NEWBURGH

RHINEBECK

Aaron M. Blum, M.D.
Lawrence Schaffer, M.D.
Carl D. Sorgen, M.D.
Herschel R. Lessin, M.D.
David L. Fenner, M.D.
Nancy A. Crocker, M.D.
Fe Aplasca, M.D.
Dominique Aristide, M.D.
Daniel Z. Aronzon, M.D.
Sharon Mae S. Britos-Neves, M.D.
Diane M. Cicatello, M.D.
Sejal Dalwadi, M.D.
Karen Desio, M.D.
Adrian Gruszko, M.D.
Marc Habert, M.D.
Lynne M. Liptay, M.D.
John Sieverding, M.D.
Michelle Patrick, PNP

Joseph F. Heavey
CEO

DATE: _____

CHILD'S NAME

DATE OF BIRTH

I authorize my provider and the administrative staff of THE CHILDREN'S MEDICAL GROUP to use and disclose protected health information to:

Doctor: _____

Address: _____

City: _____

State / Zip Code: _____

Area Code & Phone Number: () _____

Reasons for release:

- transferring to a new doctor for a court proceeding
 for a specialist other (please explain)

Specific dates of service requested: _____

This authorization shall be in force and effect for 1 year from the above date at which time it will expire. I understand that I have the right to revoke this authorization in writing, except when records have been disclosed in reliance with this authorization.

This form authorizes the release of protected health information that may include treatment pertaining to psychiatric conditions, alcohol or substance abuse, acquired immunodeficiency syndrome (AIDS) or test for infection with HIV.

If the entity receiving this information is a health care provider, the information may be re-released with the consent of the undersigned.

Signature of Parent or Guardian or patient over 18

Daytime Phone

Staff Initials
& Staff Location

- POK FSK MOD HP HJ RBK NBG

03/22/07MP