The Children's MEDICAL GROUP

Infants, Children And Adolescents

Diplomates of American Board of Pediatrics

104 Fulton Ave. • Poughkeepsie, N.Y. 12603 • (845) 452-1700 • Fax (845) 452-1752

MONDAY – FRIDAY 9AM-9PM SATURDAY – SUNDAY 9AM-5PM

✳ FISHKILL ✳ HOPEWELL JUNCTION ✳ POUGHKEEPSIE ✳ HYDE PARK ✳ RHINEBECK ✳ NEWBURGH ✳ MODENA ✳ KINGSTON ✳

Date of Request: _____

Patient Name: _____ DOB: _____

Address: _____

Phone Number: _____ Primary Care Physician: _____

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

_____
Name of Person or Entity to Receive Information

_____
Title (Physician, Parent/Guardian, Attorney)

_____
Street Address

_____
City, State and Zip Code

Reason For Request: (Check Box)

□ Change In Health Care Provider
Reason: _____

□ Legal

□ Appointment With Specialist On: _____

□ Personal Use

□ Other (specify) _____

Authorization To Discuss Health Information

□ I authorize **The Children's Medical Group** to discuss above mentioned patient's health information with:

_____ _____
Name Relationship

Records Requested:

□ All Medical Records
□ Immunizations
□ Specific Records From _____ to _____
□ Immunizations & Physical Examinations

Medical Records Copying Fees: $0.75 per page

Payment Method: □ Personal Check made payable to: The Children's Medical Group under memo please indicate for Medical Records

□ PayPal □ Cash Credit Card: □ Visa □ Mastercard □ Discover □ American Express

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, genetic testing.

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 / Guardian / Patient over 18 Date

www.childrensmedgroup.com

The Children's Medical Group Staff Use Only

# of Pages _____ x $0.75 = $ _____

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