



Diplomates of  
American Board  
of Pediatrics

*Infants, Children And Adolescents*

301 MANCHESTER ROAD SUITE 105, POUGHKEEPSIE, NY 12603  
MONDAY – FRIDAY 9AM-7PM SATURDAY 9AM-5PM

\* FISHKILL \* HOPEWELL JUNCTION \* POUGHKEEPSIE \* HYDE PARK \* RHINEBECK \* NEWBURGH \* HIGHLAND \* KINGSTON \*

**HIPAA AUTHORIZATION FORM TO RECEIVE INFORMATION FROM A PREVIOUS DOCTOR**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Description of information The Children’s Medical Group is to obtain : \_\_\_\_\_

Medical Records from date: \_\_\_\_\_ to \_\_\_\_\_

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults and records sent to you by other healthcare providers

I authorize THE CHILDREN’S MEDICAL GROUP to OBTAIN protected health information from:

Doctor/Group Name: \_\_\_\_\_

Address

Street, City & Zip Code: \_\_\_\_\_

Area Code & Phone Number: (        ) \_\_\_\_\_

**Reason for authorization:**

Transferring from another doctor/group

Returning to The Children’s Medical Group

Other (please explain) \_\_\_\_\_

I understand the following:

- a. This authorization shall be in force and effect for 1 year from the below date at which time it will expire.
- b. I have the right to revoke this authorization in writing, except when records have been disclosed in reliance with this authorization.
- c. I am signing this authorization freely and under no pressure from any individual to do so.
- d. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use. My questions regarding this form have been answered to my satisfaction.
- e. This authorization includes the disclosure of information related to ALCOHOL and DRUG ABUSE, CONFIDENTIAL HIV RELATED INFORMATION, MENTAL HEALTH TREATMENT (except psychotherapy notes) and GENETIC INFORMATION including test results.
- f. The recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand I have a right to request a list of people who may receive or use my HIV-related information without authorization.

I hereby declare that I am the patient over 18 years of age or the natural/adoptive/legal guardian for person listed above and there is no court order restricting or prohibiting my authorization for The Children’s Medical Group to obtain medical records on my behalf:

Signature of Patient or Patient’s Representative: \_\_\_\_\_ Date: \_\_\_\_\_