The Children's MEDICAL GROUP

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: _____