Diplomates of
American Board
of Pediatrics

The Children's MEDICAL GROUP

Infants, Children And Adolescents

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

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

❋ PAWLING ❋ FISHKILL ❋ HOPEWELL JUNCTION ❋ POUGHKEEPSIE ❋ HYDE PARK ❋ RHINEBECK ❋ NEWBURGH ❋ MODENA ❋ KINGSTON ❋

HIPAA AUTHORIZATION FORM TO RECEIVE INFORMATION FROM A PREVIOUS DOCTOR

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

I authorize THE CHILDREN'S MEDICAL GROUP to RECEIVE protected health information from:

Doctor: _____

Address: _____

City/State/Zip Code: _____

Area Code & Phone Number: ( ) _____

Reasons for receiving information:

□ Transferring from another doctor
□ Returning to The Children's Medical Group
□ Other (please explain) _____

Specific dates of service we are to receive: _____

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.

_____ _____
Signature of Parent / Guardian / Patient over 18 Daytime Phone

_____ □ FS □ HJ □ HP □ KG □ MN □ NB □ PK □ PW □ RB
Staff Initials & Staff Location

09/20/2012MP
Updated 01/07/2014mmp