Genesee-Transit Pediatrics, LLP
4899 Transit Road
Depew, NY 14043

Patient Authorization for the Release of Medical Records

Incoming Record Request

Use and Disclosure of Protected Health Information

Healthcare Provider Records are being Requested from: _____

Fax number: _____ **Phone Number**: _____

Address: _____

Patient Name: _____ D.O.B.: _____

Full Address: _____

My doctor has provided this HIPAA compliant request/authorization form in order to assist in requesting that you forward a copy of the medical record above. By signing this authorization, I request and authorize you to release/disclose certain protected health information (PHI) to:

Genesee-Transit Pediatrics, LLP
4899 Transit Road
Depew, NY 14043
Phone: (716) 558-5437
Fax: (716) 558-5444

This authorization permits you to use and/or disclose the following individually identifiable health information (please indicate one choice below):

Complete medical record: _____

Records pertaining to: _____

For dates of service from: _____ to: _____

This information will be used or disclosed for the following purpose: _____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that your office acted in reliance upon this authorization. My written revocation must be submitted to your Privacy Officer.

Parent / Legal Guardian requesting release of records: _____
Phone number: _____

Authorizing Signature: _____ **Date**: _____

Please choose one: ◯ Patient ◯ Parent ◯ Legal Guardian