Transfer Medical Record out of Genesee-Transit Pediatrics, LLP

Patient Authorization for the Release of Medical Records

By signing this authorization, I authorize**:** **Genesee-Transit Pediatrics, LLP**

4899 Transit Road, Depew, NY 14043

Phone: 716-558-5437 Fax: 716-558-5444

To use and/or disclose certain Protected Health Information (PHI) about**:**

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

Full Address: _____

To the following recipient: _____

(New providers name and/or practice name)

_____

(Street address, zip code and state)

_____

(Phone number) (Fax number)

Please check one below:

☐ Complete Medical Record

☐ Records pertaining to: _____

☐ For date of service from: _____ to: _____

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

This authorization will expire on: _____

Genesee-Transit Pediatrics will ◯/ will not◯ receive compensation from a third party in exchange for using or disclosing the above specified information.

I understand that:

*That I have the right to refuse to sign this authorization.

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 Genesee-Transit Pediatrics, Privacy Officer.

Parent / Legal Guardian requesting release of records: _____

Phone number: _____

Authorizing Signature: _____ **Date**: _____

Please select one: ◯ Patient ◯ Parent ◯ Legal Guardian