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(s): ____ D.O.B.: _______________

____ D.O.B.: _______________

____ D.O.B.: _______________

____ D.O.B.: _______________

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