AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
ALL FIELDS MUST BE COMPLETED

COMPLETE ALL SECTIONS, DATE AND SIGN

I.

Patient Name	Date of Birth
Address	Phone

II. **I authorize:** **Summerwood Pediatrics**

☐ **4811 Buckley Rd.**
Liverpool, NY 13088
Phone: (315) 457-9966
Fax: (315) 457-9854

☐ **5700 West Genesee St.**
Camillus, NY 13031
Phone: (315) 488-2868
Fax: (315) 488-6759

☐ **SEND** my medical records to: ☐ **OBTAIN** my medical records from:

Person/Organization Name	
Address	
City/State/Zip code	
Phone	Fax

III. **The purpose or need for disclosure is:**

☐ Transfer Medical Care ☐ Personal Use ☐ Attorney ☐ Other (Specify) _____

If transferring out of practice, please specify reason:

☐ Aged-out of practice ☐ Moving out of area ☐ Billing issues (please specify) _____

☐ Unhappy with the practice (please state why) _____

IV. **The information to be disclosed from my health record:** (*Check appropriate box/boxes. Only the selected information will be released)*

☐ Entire medical record- including previous provider records & mental health **(other than Psychotherapy Notes)**

☐ Information related to *(specify)* _____

☐ The period of _____ to _____

☐ Other *(specify)* _____

If you would like the following sensitive information disclosed, check applicable box/boxes below:

☐ Alcohol/Drug Abuse ☐ Sexually Transmitted Diseases ☐ HIV/AIDS Related Treatment

Medical record requests could take up to 2 weeks to be processed.

V.
- I understand that my medical and/or billing information may be re-disclosed and no longer protected by federal health information privacy regulations if the recipient described on this form is not required by law to protect the privacy of your information.
- I understand and am aware of security risks associated with unsecure transmission of my Personal Health Information (PHI) by fax. I accept this security risk and request to have my PHI sent by the method indicated above.
- I understand my medical records may contain information relating to **Alcohol/Substance abuse, STD** and/or **HIV/AIDS related information.** *This information will not be released unless the appropriate boxes have been checked pertaining to this information.*
- I understand that I have the right to inspect and/or receive a copy of the information described on this authorization form by completing a request for access form.
- I understand I have the right to receive a copy of this authorization form after I have signed it.
- I understand I may revoke this authorization, in writing, at any time.
- This authorization will terminate ONE YEAR from the date of my signature.

Patient Signature:	Date:
Printed Name:	Relationship: