



Four Seasons Pediatrics  
532 Moe Road  
Clifton Park, NY 12065  
Ph 518-383-2425  
Fax 518-383-3255

**Authorization for Release of Health Information**  
(Medical records being sent TO our office)

Name of Facility records are being requested **from:**

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

I, the undersigned, hereby authorize the above named facility to release / disclose medical information to **Four Seasons Pediatrics, 532 Moe Road Clifton Park, NY 12065** regarding the following:

Name of Patient 1 \_\_\_\_\_ DOB \_\_\_\_\_

Name of Patient 2 \_\_\_\_\_ DOB \_\_\_\_\_

Name of Patient 3 \_\_\_\_\_ DOB \_\_\_\_\_

Name of Patient 4 \_\_\_\_\_ DOB \_\_\_\_\_

Current Address \_\_\_\_\_

\_\_\_\_\_

Phone number \_\_\_\_\_

**Purpose of disclosure:** Four Seasons Pediatrics will be my new primary care doctor \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Specific information to be released:**

- All medical information
- Medical summary containing growth charts, immunization record and labs.
  
- Information regarding specific injury or treatment for \_\_\_\_\_
- Radiology reports available
- Laboratory results
  
- Other (specify) \_\_\_\_\_
- If authorizing please indicate by signature to include the following:

Alcohol/Drug Treatment                      signature \_\_\_\_\_ date \_\_\_\_\_

Mental Health information                      signature \_\_\_\_\_ date \_\_\_\_\_

HIV- related information                      signature \_\_\_\_\_ date \_\_\_\_\_

**Duration:**

This authorization will become effective immediately and shall remain in effect for one year from the date of signature. Unless specified by dates or defined event: \_\_\_\_\_.

**Revocation:**

This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. Written revocation may be addressed to: Privacy Officer, Four Seasons Pediatrics 532, Moe Road Clifton Park, NY 12065.

**Re-disclosure:**

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. If this authorization indicates by signature HIV, Drug/ Alcohol treatment, mental health information is being disclosed the recipient is prohibited from redisclosing such information without authorization unless permitted to do so under federal and state law.

**New Patient Appointments with our office:**

Four Seasons Pediatrics has a policy where there is a fee charged for appointments cancelled without 24 hours notice (currently \$25.00) or failing to arrive at your scheduled appointment time (currently \$50.00). My signature below serves as the understanding and agreement of this policy.

A copy of this authorization is as valid as the original. I have the right to receive a copy of this authorization.

**Print Name** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Relationship to patient** \_\_\_\_\_