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 FROM our office)

I, the undersigned, hereby authorize **Four Seasons Pediatrics,** located at **532 Moe Road Clifton Park, NY 12065,** to release / disclose medical information 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 _____

Name of entity records are being sent **TO:** (records sent not for continuation of care are subject to 75 cents per page NYS max fee)

Name _____

Address _____

_____

Phone Number _____

Fax Number _____

Purpose of disclosure: I am transferring my medical care to a new doctor's office _____

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 if available
- ❑ Laboratory results if available

- ❑ Other (specify) _____
- ❑ If authorizing items below, 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.

Previous / Outstanding balance with our office:
I understand that if I have an outstanding account balance currently with Four Seasons Pediatrics, transferring care to a new location or doctor does not resolve the amount due. I am still responsible for payment of outstanding amounts and will billed additional fees and charges if the balance remains unpaid.

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 _____