WESTSIDE PEDIATRIC GROUP, LLP
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Rochester, NY 14624-3403
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Authorization for Release of PHI

Today's Date:_____
Patient's Name:_____ Date of Birth:_____
Address:_____
City/State/Zip Code:_____
Patient's Phone #: ( )_____

Select the following types of Authorization that apply. Psychiatric and alcohol/drug treatment records are not included in this authorization unless you complete the following section giving specific permission to do so.

__Medical/Surgical Information __ Psychiatric Information __Alcohol/Drug Abuse Information

Please check all information that applies:

__All Information __Progress Notes __Hospital Information __Treatment Plans __ H & P
__Lab Results __Radiology Reports __Psychiatric Information __Immunizations
__Other (please specify):_____

__ I authorize Westside Pediatric Group to **RELEASE** my protected health information **TO**:
Name:_____ City:_____ State_____
Address:_____ Zip:_____
Phone #:_____ Fax#:_____

__I authorize Westside Pediatric Group to **OBTAIN** my protected health information **FROM:**
Name:_____ City:_____ State_____
Address:_____ Zip:_____
Phone #:_____ Fax#:_____

PURPOSE FOR THIS REQUEST: (Circle one)
2nd Opinion Personal Insurance Transfer Other _____
Please specify

I understand that:

- My right to healthcare treatment is not conditioned on this authorization
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the bottom of this form, except where a disclosure has already been made in reliance from my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by the privacy regulations the information stated above could be re-disclosed. (If you are not the intended recipient, or the agent responsible to deliver to the intended recipient, you are hereby notified that nay disclosure, copying or distribution of this information is **strictly prohibited**.)
- There may be a charge for the requested records.

Signature of Patient or legal representative: _____ Date_____

Relationship to Patient: _____
(if requestor is not the patient)