Western New York Pediatric Associates

5800 Big Tree Road
Orchard Park, NY 14127
Phone 716-662-7337 Fax 716-662-0641

RELEASE OF INFORMATION AUTHORIZATION

Please Print Clearly

Last Name:	**First Name:**	**MI:**
Date of Birth:		
Address:		
City:	**State:**	**Zip Code:**
Phone: (Home) ( ) -	**(Alternate) ( ) -**	

I, or my authorized representative, request that health information regarding my care and treatment is **released by/obtained from** Western New York Pediatrics as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I understand that:

- I have the right to revoke this authorization at any time by writing to the health care provider listed. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioning upon my authorization of this disclosure.
- Information disclosed under this authorization might be redisclosed by the recipient, and this redisclosure may no longer be protected by federal or state law.

PLEASE CHECK ONE: _____ Release Information To: _____ Obtain Information From:

Person/Organization: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: ( ) _____-_____

Reason for Request: _____

Information requested: _____ Medical Summary _____ Immunization Record
_____ Chart Notes (last 2 years) _____ Growth Chart
_____ Lab/X-Ray (last 2 years)

For a transfer out of the practice <u>as a courtesy</u> we will release the above information <u>free of charge up to 50 pages,</u> over 50 pages you will be charged <u>$0.75 per page</u>. If you are requesting additional information you will be charged $0.75 per page. Request for personal copies of records will be $0.75 per page.

PLEASE SPECIFY ADDITIONAL INFO NEEDED: _____

_____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

<u>If over 18 years of age, the patient MUST sign this form**</u>**