HUDSON HEIGHTS PEDIATRICS, PC
180 CABRINI BOULEVARD
NEW YORK, NY 10033
OFFICE: (212) 781-0400
FAX: (212) 781-0060
WWW.HUDSONHEIGHTSPEDIATRICS.COM

AUTHORIZATION TO TRANSFER HEALTH INFORMATION/MEDICAL RECORDS

Patient Name: Patient Address:

Reason for records request:

Email/fax where records are to be sent:
(please note: some records are too large to be faxed)

I hereby authorize the release of protected health information pertaining to my child/ren's medical care at your facility.

I authorize disclosure of the following information from my medical record (circle where applicable:)

Immunizations Lab Reports Radiology and imaging reports Discharge Summary
Clinical Documentation Pathology Reports ALL of the Above
Other____

The purpose(s) for which disclosure is authorized (circle where applicable):

Medical Care Insurance Immunization Other (specify)_____________

I understand that:

1. I may inspect or receive a copy of the protected health information described by this authorization upon payment of a reasonable fee.
2. This Authorization is voluntary and that I have the right to refuse to sign it.
3. I may revoke this Authorization at any time by providing a written notice revocation as specified by the Notice of Privacy Practice; however, such revocation would not affect any action taken by Hudson Heights Pediatrics, PC in reliance on this authorization before receipt of my written revocation.
4. This authorization will expire on _______/________/_______ (fill in if less than 1 year) or year after being signed.
5. The information disclosed pursuant to this authorization, except information protected by Federal and/or State regulations about confidentially of drug and alcohol abuse records, HIV and Mental Health, may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations or other applicable state laws.
6. Medical records may contain genetic testing information including test results.
7. This Authorization is also applicable to patients with drug or alcohol related diagnosis, protected by title 42 of the Code of Federal Regulations.

____
Signature of patient/personal representative (e.g. legal guardian) Date: ______/_____/_____

____
If personal representative, relationship to patient (print name)