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

Authorization for Release of Health Information

(Medical records being sent TO our office)

If sending entire record ONLY send by mail via CD OR USB OR email to https://sendsafe.to/exchange@fourseasonspediatrics.com

Otherwise only send last well visit, medical summary, growth charts, immunizations and labs

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 _____