Authorization for Outgoing Release of Health Information
(Medical records being sent FROM Four Seasons Pediatrics)

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 _____ DOB _____

additional patient _____ *DOB* _____

additional patient _____ *DOB* _____

Best 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/Site _____

Address _____

_____

Phone Number _____

Fax Number _____ *(we use fax to transfer records)*

Please indicate the reason for records release and/or additional comments:

_____

_____

_____

Specific information to be released:

- ❑ All medical information
  -or-
- ❑ Medical summary containing growth charts, immunization record and labs.
- ❑ **Only** Information regarding specific injury or treatment for _____
- ❑ **Only** Radiology reports if available
- ❑ **Only** 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 _____

Please note that we are unable to release certain records if they were not originated/created by our office.

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 _____