Williamsville Pediatric Center
2733 Wehrle Dr Suite 100
Williamsville, NY 14221
716-631-3510; 716-631-9627 (fax)

Authorization for the Release of Medical Records

Permission is hereby granted to the Williamsville Pediatric Center for the release of Medical Records of:

_____ _____
(Patient's Name) (Birth Date)

_____
(Street Address)

_____
(City, State, Zip Code)

If applicable*, this information is to be sent to:

_____
_____
_____

Information to be released:
( ) Summary which is free, that includes immunizations and brief history
( ) Complete Medical Records
( ) Dates of Service From: To:
( ) Records Pertaining To:

_____

This section must be completed for patients born after May 1st, 1996

Authorization for release of confidential HIV related information (Human Immunodeficiency Virus that causes AIDS)

Confidential HIV related information is any information indicated that a person has an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV. Since May 1st, 1995, all newborn infants in New York State have been treated for HIV prior to their hospital discharge.

Under NYS Law, except for certain people, confidential HIV related information only can be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form.

If you sign this form, HIV related information can be given to the people listed on the form. You do not have to sign the form and you can change your mind at any time.

If you experience discrimination because of the release of HIV/related information, you may contact the NYS Division of Human Rights at (718) 741-8400 or NYC Commission of Human Rights at (212) 306-7450.

( ) I authorize release of HIV related information for the purpose of maintaining a comprehensive medical record for the health care providers

( ) I do not give permission to the release of HIV related information

_____

My questions about this form have been answered. I know that I do not have to allow releases of HIV related information and that I can change my mind at anytime. I release the Williamsville Pediatric Center from all legal responsibility that may arise from this act. I understand that there may be a charge for the completion of this medical records release request (includes photocopying fees, postage, and labor).

* Records will only be sent if not completed at the time you relocate.

_____ _____
Print Name (Patient/Legal Guardian/Parent) (Relationship to Patient if applicable)

_____ _____
Signature Date

Please indicate below the reason for leaving:
( ) Moving out of area ( ) Insurance ( ) Closer to Home ( ) Dissatisfied ( ) Age