Williamsville Pediatric Center
2733 Wehrle Drive
Williamsville, NY 14221
Telephone: (716) 631-3510
Fax: (716) 631-9627

AUTHORIZATION FOR RELEASE OF INFORMATION FOR CONTINUING PATIENT CARE

I, The Parent of: ______________________________ DOB: ______________,
authorize my child's/children's physician and/or their administrative and clinical staff to:

Receive from:

____
Name of Facility/Individual

____
Address

____
Fax Number Phone Number

Release to:

Williamsville Pediatric Center
Name of Facility/Individual

2733 Wehrle Drive, Williamsville, NY 14221
Address

(716) 631-9627
Fax Number

(716) 631-3510
Phone Number

Information concerning the history, treatment or examination of the above-named patient for the purpose of continuing health care. I understand that this authorization is voluntary, I understand that if the person or organization I authorize to receive/release my protected health information is not a health plan or health care provider; my health information may no longer be protected by federal privacy regulations once it is disclosed.

My protected health information that may be disclosed includes ______________ to ______________:
Entire Medical Record _____ Treatment Record _____ Diagnostic Tests ____ Other _____ Medical Summary ____

I give special authorization for the following information to be used or disclosed:

Psychological/Psychiatric/Mental Health Information (this includes Psychotherapy notes)
HIV/AIDS Information Substance Abuse Information

This authorization shall be effective until ______________, at which time this authorization will expire.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notifications to Williamsville Pediatric Privacy Officer at 2733 Wehrle Drive, Williamsville, NY 14221. I understand that, even if I revoke my authorization, it will be effective to the extent Williamsville Pediatrics has relied on it to use or disclose my protected health information, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that Williamsville Pediatrics Notice of Practices Privacy discusses my right to revoke and my other rights.

I understand that Williamsville Pediatric Center will not condition my treatment on whether I sign this authorization except: (1) if my treatment is related to research, or (2) the health care services are being provided to me solely for the purpose of disclosing my health information to a third party, such as a referring physician or a return to work authorization.

I have read (or had read to me) the above authorization and I understand my rights with regard to my protected health information, I have been provided with a copy of the authorization.

____
Signature of Patient or Legally Responsible Person

____
Date

____
Print Name of Patient or Legally Responsible Person

____
Relationship to Patient

____
Address

____
Social Security Number