



**Garden City Pediatric Associates, Inc.**

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**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Your medical records cannot be released until this form is completed and signed by the patient, parent, or legal guardian. As you complete each step, check off the box at the left. There may be a processing fee associated with this request

**PLEASE PRINT**

<p>Step 1 Completed</p> <input type="checkbox"/>	<p><b>STEP 1: <u>Patient Information</u></b></p> <p>PATIENT NAME: _____ DATE OF BIRTH: _____  <small>Last First</small></p> <p>ADDRESS: _____  <small>Street City State Zip</small></p>
<p>Step 2 Completed</p> <input type="checkbox"/>	<p><b>STEP 2: <u>Disclosing Provider</u></b></p> <p>I hereby authorize: _____ M.D.</p> <p>Address: _____          _____</p>
<p>Step 3 Completed</p> <input type="checkbox"/>	<p><b>STEP 3: <u>Information to be disclosed or released</u></b></p> <p>To release the following information: Please specify:</p> <p><input type="checkbox"/> <u>ALL RECORDS</u> OR</p> <p><input type="checkbox"/> <u>ALL RECORDS EXCEPT</u> _____ OR</p> <p><input type="checkbox"/> <u>ONLY RECORDS RELATING TO:</u> _____ OR</p> <p><input type="checkbox"/> <u>RECORDS OF TREATMENT FROM:</u> _____ <u>TO</u> _____ OR</p> <p><input type="checkbox"/> <u>OTHER</u> _____</p>
<p>Step 4 Completed</p> <input type="checkbox"/>	<p><b>STEP 4: <u>Receiving provider and purpose of disclosure</u></b></p> <p>TO: _____          _____          _____</p> <p>FOR: _____</p>

<p>Step 5 Completed</p>	<p><b>STEP 5: <u>Statement of understanding and signature</u></b></p> <p>Your signature on the next page indicates that you agree to the disclosure or release of medical information described above <i>and</i> that you understand the following:</p> <ul style="list-style-type: none"> <li>• This authorization is valid for 90 days from the date of signature.</li> <li>• You may revoke this authorization at any time by sending a written request for revocation to the provider named in Step 2 above. This revocation, however, will not affect any actions taken by the releasing provider before he/she received my written revocation.</li> <li>• Our medical treatment cannot and will not be dependent upon your signing this authorization.</li> <li>• The medical information that is the subject of this form <i>may not be protected by the federal privacy regulations if or when it is redisclosed</i> by the person, group, or institution you are authorizing to receive it.</li> <li>• <b>There is a charge for each request for copies of medical records in accordance with regulations established by the Board of Registration in Medicine.</b></li> </ul> <p style="text-align: right;">_____ Patient's Signature</p> <p>_____ Witness Signature</p> <p style="text-align: right;">_____ Parent's or Guardian's Signature</p>
<p>Step 6 Completed</p>	<p><b>STEP 6: <u>Sensitive Information:</u></b></p> <p>I AGREE TO THE RELEASE of the information in my medical record that relates to drug and/or alcohol abuse, psychiatric care, history of sexually transmitted disease, social service consultations, hepatitis testing/treatment, and/or other sensitive information.</p> <p>_____ Signature of Patient or Legal Guardian</p> <p style="text-align: right;">_____ Date</p>
<p>Step 7 Completed</p>	<p><b>STEP 7: <u>HIV Information:</u></b></p> <p>IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW. I AGREE TO THE RELEASE OF THE HIV INFORMATION IN MY MEDICAL RECORD.</p> <p>_____ Signature of Patient or Legal Guardian</p> <p style="text-align: right;">_____ Date</p>

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Garden City Pediatric Associates will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.**