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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

Step 1 completed ☐	**STEP 1:** **Patient Information** PHONE #_____ PATIENT NAME:_____ DATE OF BIRTH:_____ Last First ADDRESS:_____ Street City State Zip
Step 2 completed ☐	**STEP 2:** **Disclosing Provider** I hereby authorize:_____M.D. Address: _____
Step 3 completed ☐	**STEP 3:** **Information to be disclosed or released** To release the following information: Please specify: ☐ LAST TWO YEARS ONLY (STANDARD TRANSFER) OR ☐ ALL RECORDS EXCEPT_____OR ☐ ONLY RECORDS RELATING TO:_____OR ☐ RECORDS OF TREATMENT FROM:_____TO_____OR ☐ OTHER_____ ☐ ALL RECORDS
Step 4 completed ☐	**STEP 4:** **Receiving provider and purpose of disclosure** TO: _____ _____ **We would welcome any feedback about the reason for transferring your care:** _____

Step 5 completed ☐	**STEP 5:** **Statement of understanding and signature** Your signature on this page indicates that you agree to the disclosure or release of medical information described above *and* that you understand the following: • This authorization is valid for 90 days from the date of signature. • 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. • Our medical treatment cannot and will not be dependent upon your signing this authorization. • The medical information that is the subject of this form *may not be protected by the federal privacy regulations if or when it is redisclosed* by the person, group, or institution you are authorizing to receive it. • **There is a charge for each request for copies of medical records in accordance with regulations established by the Board of Registration in Medicine up to a maximum of $50.** _____ Patient's signature _____ _____ Witness Signature Parent's or Guardian's Signature
Step 6 completed ☐	**Step 6:** **Sensitive Information:** 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. _____ _____ Signature of Patient or Legal Guardian Date
Step 7 completed ☐	**Step 7:** **HIV Information:** 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.** _____ _____ Signature of Patient or Legal Guardian Date
	I UNDERSTAND THAT UPON TRANSFER OF CARE, GARDEN CITY PEDIATRIC ASSOCIATES, LLC IS UNABLE TO PROVIDE APPOINTMENTS, TELEPHONE TRIAGE AND/OR REFERRALS. _____ Initial

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.