SOUND BEACH
PEDIATRICS
41° 02' 56" N | 73° 33' 50" W

Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/_____

I, _____ hereby authorize:

Sound Beach Pediatrics
2001 West Main Street, Suite 132
Stamford, CT 06902
Tel: (203) 363-0123

☐ to RELEASE information from my medical record TO: ☐ to OBTAIN information FROM:

(Doctor/Clinic/Hospital): _____

Address: _____

_____

Telephone: _____ Fax : _____

Please release the following:

___ **All health information (including growth charts and vaccination records)**

___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports

___Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

___ Yes, I consent to the release of this information.
___ No, I do not consent to the release of this information.

Purpose of disclosure:
___ Treatment/ Continuing medical care
___ At patient's request
___ Other _____

I understand that I may revoke this authorization at any time by providing written notice to the provider releasing the information. If I choose to do so, my revocation will not affect any actions taken before receiving my revocation. This authorization shall remain valid until such time as it is revoked in writing.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient(s) and may no longer be protected by HIPAA Privacy regulations. I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature: _____ Date: ____/____/____

Print Name: _____ Relationship to Patient: _____