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Pediatric Endocrinology of NY

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's name: _____
Last First DOB

Address: _____
Street City State Zip

Patient's Phone: _____
Home Work Mobile

I hereby authorize **PEDIATRIC ENDOCRINOLOGY of NY** to release medical information in my Records to:

I understand that copies of my medical records and any other information contained in my records may be provided to the person or persons named in this release. I understand that there will be a charge for my medical records. I authorize release of the following information:

___ Entire record (this includes everything; old records, films, test results, notes, correspondence, billing information, and anything else that may be in the chart but does not include items that require special authorization).

___ Specific information only (Identify the specific information you want released: notes, labs, x-rays, etc.)

We are not authorized to release information received from another doctor's office or hospital. For release of that information please contact the relevant doctor's office or hospital. This is in compliance with the **HIPPA** guidelines.

Please allow **10 business** days for all requests.

This authorization will automatically expire one year from the date signed by you. I understand that I may revoke this consent at any time to the extent that it has already been relied upon.

Signed: _____ Date: _____

Parent or Legal Guardian