FORESTREAM PEDIATRICS, LLP
4711 Transit Road, Suite 1,
Depew, NY 14043
716-668-5331

Patient Record Release Authorization – Incoming Record Request
Use and Disclosure of Protected Health Information to Forestream Pediatrics, LLP

Name of Doctor, Practice, Hospital, Clinic or other Health care Provider Records are being Requested from:

_____

Address: _____

_____

Phone Number: _____

Patient Name: _____DOB:_____
Address: _____

_____

Phone Numbers _____

Dear Health Care Provider:
My doctor has provided this HIPAA compliant request/authorization form in order to assist me in requesting you forward copies of my medical record. By signing this authorization, I request and authorize you to release/disclose certain protected health information (PHI) about me to:

Forestream Pediatrics, LLP
4711 Transit Road, Suite 1
Depew, NY 14043
Fax (716) 668-5370

This authorization permits you to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, *such as dates(s) of service*, level of detail to be released or mark the appropriate box)

_____

_____

☐Pertinent medical records including last **well child check, growth chart** and **immunization records**

☐Radiology Reports ☐Laboratory results ☐Specialty Studies

This information will be used or disclosed for the following purpose:

_____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that your office acted in reliance upon this authorization. My written revocation must be submitted to your Privacy Officer.

Parent / Legal Guardian _____
Phone Numbers _____

Authorizing Signature: _____Date:_____

☐Patient ☐Parent ☐Legal Guardian

This Authorization will expire on (Date):_____