FORESTREAM PEDIATRICS, LLP
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Depew, NY 14043
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Patient Record Release Authorization – Record Request Outgoing
Use and Disclosure of Protected Health Information from Forestream Pediatrics, LLP

By signing this authorization, I authorize Forestream Pediatrics, LLP to release/disclose certain protected health information (PHI) about me to:

Physician Name: _____

Practice Name: _____

Address: _____

_____

Phone Number: _____

This authorization permits Forestream Pediatrics, LLP to release/disclose or use 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 ☐Immunization Records ☐Radiology Reports

☐Blood test results ☐Specialty Studies

Include (indicate by initialing)
____Alcohol/Tobacco/Drug Treatment _____Mental Health Information _____HIV Information

The information will be released/disclosed or used for the following purpose:

☐Transferring medical care ☐Moving from area ☐Specialist appointment

☐Personal records ☐Other_____

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 Forestream Pediatrics, LLP has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Forestream Pediatrics, LLP (address listed above).

Patient Name: _____DOB:_____
Address: _____

_____

Phone Numbers: _____

Parent / Legal Guardian: _____
Phone Numbers: _____

Authorizing Signature: _____Date:_____

☐Patient ☐Parent ☐Legal Guardian

This Authorization will expire on (Date):_____