Caring Pediatric Associates

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MEDICAL RECORD RELEASE

THIS AUTHORIZATION PERMITS:

____
DOCTOR OR HOSPITAL NAME

____
DOCTORS PHONE NUMBER AND FAX

PLEASE SEND CHILD'S EXAM AND IMMUNIZATION RECORDS TO:
CARING PEDIATRIC ASSOCIATES
37 MERIDIAN ROAD, LEVITTOWN N.Y. 11756
Or email records to: nancy@caringpeds.org

Last Checkup Exam and Immunization Records ONLY

CHILD'S NAME_________________________________ DOB:_____________

CHILD'S NAME_________________________________ DOB:_____________

CHILD'S NAME_________________________________ DOB:_____________

CHILD'S NAME_________________________________ DOB:_____________

PARENT'S NAME: ____

ADDRESS: ____

PHONE NUMBER: ____

WHEN MY INFORMATION IS USED FOR DISCLOSED PURSUANT TO THIS AUTHORIZATION, IT MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY THE FEDERAL HIPPA PRIVACY RULE. I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING EXCEPT TO THE EXTEND CARING PEDIATRIC HAS ACTED IN RELIANCE UPON THIS AUTHORIZATION. MY WRITTEN REVOCATION MUST BE SUBMITTED TO CARING PEDIATRIC PRIVACY OFFICER.

SIGNED BY ___________________________ RELATIONSHIP TO PATIENT__________________ DATE:__________