

Caring Pediatric Associates

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MEDICAL RECORD RELEASE

THIS AUTHORIZATION PERMITS:

DOCTOR OR HOSPITAL NAME

DOCTOR'S PHONE NUMBER AND FAX

PLEASE SEND CHILD'S EXAM AND IMMUNIZATION RECORDS TO:
CARING PEDIATRIC ASSOCIATES
37 MERIDIAN ROAD, LEVITTOWN, N.Y. 11756

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. IT 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 CARING PEDIATRIC HAS ACTED IN RELIANCE UPON THIS AUTHORIZATION. MY WRITTEN REVOCATION MUST BE SUBMITTED TO THE CARING PEDIATRIC PRIVACY OFFICER.

SIGNED BY _____ RELATIONSHIP TO PATIENT _____ DATE: _____