PAK
PEDIATRIC ASSOCIATES OF KINGSTON
Taking Exceptional Care of the Next Generation since 1967

NEPA
BREASTFEEDING CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION TO PEDIATRIC ASSOCIATES OF KINGSTON

Patient Name _____ Date of Birth ___/___/_____
First MI Last

I authorize the release of the protected health information, including copies of the medical record, for the patient named above from:
Name/Facility
Attention: Medical Records
Address
City & State
Phone **Fax**

The information to be released will cover the time period from _____ to _____

I authorize the release of the protected health information, including copies of the medical record of care, of the patient named above to:

Pediatric Associates of Kingston, LLC
425 Tioga Avenue
Kingston, PA 18704-5698
Telephone (570) 288-6543 Fax (570) 288-7130

J.R. Kile, MD, MHA J.C. Gaudio, MD
S.J. Leung, MD A.G. Reymunde, MD A.M. Johnson, MD
A. Flaherty, PA-C A. Sabatino, CRNP

_____ _____
Patient Signature **Date**

_____
Parent/Guardian Signature **Relationship to Patient** **Date**