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

NEPA
BREASTFEEDING CENTER

Initial when Complete: PSR: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

Patient Information:

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

Address _____
Street or PO Box City State & Zip Code

Phone Number (_____)_____-_____

Physician _____ Chart # _____ Sex _____

I authorize Pediatric Associates of Kingston, LLC to release my/my child's protected health information, including copies of my medical record of care, to the following person(s) at the address/facility listed below:	
Name/Facility	
Name	**Telephone**
Address	**Fax**
City & State	**Zip**
Information Requested ☐ Medical Records, including Immunizations **($20 per patient)** **or** ☐ Visit History (May 1991 to Present), including Immunizations **($5 per patient)**	

If Transferring Out of Office Please Give Reason:

____ Age **_____Personal Use**

____ Relocation

____ Unsatisfied (Please give reason)_____

Signature:_____ **Date:_____**

I authorize Pediatric Associates of Kingston, LLC to release information contained in the Medical Record of the patient named on this form. I understand the information may include the items initialed below (if it is contained in your/your child's medical record): **PLEASE INITIAL ALL ELEMENTS THAT YOU AGREE TO HAVE RELEASED**	
Initial if may be released	**HIV test results** Specify dates:
Initial if may be released	**Alcohol and Drug Abuse Treatment Records** Federal law prohibits any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by federal law. I can revoke this authorization in writing at any time, except to the extent that Pediatric Associates of Kingston, LLC has relied on it.
Initial if may be released	**Details of mental health diagnosis and/or treatment provided by a psychiatrist, psychologist, mental health clinical nurse specialist, or licensed mental health clinician** I understand that my permission may not be required to release this information for payment purposes.
Initial if may be released	**Confidential communications with a licensed social worker**
Initial if may be released	**Information related to a sexually transmitted disease**
Initial if may be released	**Information related to diagnosis or treatment of hepatitis**
Initial if may be released	**Information related to diagnosis or treatment of pregnancy**
Initial if may be released	**Information related to spouse abuse and/or child abuse or neglect**
Initial if may be released	**Information concerning family violence and/or domestic violence victims' counseling**
Initial if may be released	**Information concerning rape and/or sexual assault counseling**

I hereby authorize Pediatric Associates of Kingston, LLC ("Pediatric Associates") to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that Pediatric Associates cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Pediatric Associates may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date, unless otherwise specified. I can, however, cancel this authorization in writing at any time, except to the extent that Pediatric Associates has relied upon it. For example, if I cancel it after Pediatric Associates has sent the requested records, Pediatric Associates will not retrieve those records. Instructions for canceling this authorization are included in the Pediatric Associates Notice of Privacy Practices.

I understand that Pediatric Associates will continue to provide care, even if I do not authorize this release.

I understand that Pediatric Associates charges a fee for copying medical records, as identified above, and agree to pay this fee at the time of my request.

_____ Date _____

Patient Signature

_____ Date _____ Relationship to Patient _____

Parent/Guardian Signature