Caring Pediatric Associates
37 Meridian Road
Levittown, NY 11756
www.caringpeds.com

Patient Authorization for Practice Release

Protected Health Information to Third Parties

This authorization permits:

____
Doctor or Hospital Name

____
Address

Please send child's records to: Caring Pediatric Associates
37 Meridian Road
Levittown, NY 11756

The following individually identifiable health information (specifically describe the information to be released, such as dates of service, level of detail to be released, origin of information, etc.) I understand that this will include information relating to AIDS or HIV infection if applicable.
The complete history records in your possession, concerning my child/children's treatment:

Child's Name ______________________________ DOB: __________________

Child's Name ______________________________ DOB: __________________

Child's Name ______________________________ DOB: __________________

Child's Name ______________________________ DOB: __________________

____
Parent's Name

____
Address

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 HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent the Caring Pediatric has acted in reliance upon this authorization. My written revocation must be submitted to Caring Pediatric privacy officer.

Signed by ________________________________ ______________________ Date ______________
Signature of Patient or Legal Guardian **Relationship to Patient**