Jamestown Pediatric Associates
816 Fairmount Ave
Jamestown, NY 14701
Phone: (716) 664-2589
Fax: (716) 483-6834

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ D.O.B: _____

Address: _____Phone: _____

City: _____ State: _____Zip: _____

Information or Records to be released _____

Purpose for request (circle one) Transfer Personal Insurance Other

( ) I authorize Jamestown Pediatric to **RELEASE** information to:

Name: _____

Address: _____

Phone: _____

Fax: _____

( ) I authorize Jamestown Pediatric to **OBTAIN** information from:

Name: _____

Address: _____

Phone: _____

Fax: _____

I understand that:

This authorization will be deemed valid unless terminated or revoked in writing by the patient, if of age to consent or emancipated: or if under the age of 18, the patient's custodial parent or other legal guardian. I understand that this authorization may be revoked at any time except to the extent that Jamestown Pediatric Associates has already relied upon it. The information that I have authorized to disclose could potentially be re-disclosed by the person receiving the information and may no longer be protected under the federal privacy regulations. I further understand that Jamestown Pediatric Associates is NOT responsible for any such re-disclosures. I have the right to limit the authorization and that such restrictions must be sent in writing to Jamestown Pediatric Associates in writing to the address above.

_____

Signature Date

_____

Printed Name Relationship to Patient