1700 Hudson Avenue
Rochester, NY 14617
Phone (585) 342-5665
Fax (585) 342-2345
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Medical Release Form

Patient Name____________________________________ Date of Birth:_____________

Address:____

City/State/Zip:___________________________________ Phone:_________________

Date of Request____

Please Check Appropriate Box

☐ Transferring into Portland Pediatric Group, LLP. (PLEASE DO NOT FAX RECORDS)

☐ Transferring out of Portland Pediatric Group, LLP.

I authorize Portland Pediatric Group, LLP, to obtain information from/release information to:

Name of Provider/Facility:____

Address:____

City/State/Zip:____

Phone:_____________________________________Fax:___________________________

These records include:

☐ All medical information available from the last five years. This includes psychiatric history, mental illness history, drug/alcohol use or abuse history, and information including sexually transmitted disease history and treatment.

☐ Only medical history from the last five years. This excludes psychiatric history, mental illness history, drug/alcohol use or abuse history, and information including sexually transmitted disease history and treatment.

☐ Other:____

I understand that:

- My rights to healthcare treatment is not condition on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care of medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information requires additional authorization.

Signature of Patient/Legal Representative: _______________________ Date:_________

Relationship to Patient (if requester is not the patient): ___________________________