

# Tonawanda/Island Pediatrics

## PATIENT AUTHORIZATION FORM

By signing this authorization, I authorize Tonawanda/Island Pediatrics to use and/or disclose certain protected health information about:

\_\_\_\_\_  
\_\_\_\_\_  
(patient's name) (birth date)  
\_\_\_\_\_  
(street address)  
\_\_\_\_\_  
(city, state, zip code)

used/disclosed:

**To the following recipient:**  
record

\_\_\_\_\_  
to \_\_\_\_\_  
(name)  
\_\_\_\_\_  
(street address)  
\_\_\_\_\_

Description of information to be

- Summary of care  
 Complete medical

Dates of service from \_\_\_\_\_

Records pertaining to

( city, state, zip code)

The information will be used or disclosed for the following purpose:

\_\_\_\_\_  
\_\_\_\_\_

This authorization will expire on: \_\_\_\_\_

Tonawanda Pediatrics will \_\_\_\_\_, will not \_\_\_\_\_ receive compensation from a third party in exchange for using or disclosing the above specified information.

I understand that:

- I have the right to refuse to sign this authorization. Treatment will not be conditioned on my providing this authorization.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by the federal HIPAA Privacy Rule.
- I may revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

Tonawanda Pediatrics, 3950 E. Robinson Rd., Suite 205 W. Amherst, NY 14228,  
attention Privacy Officer.

- I will be charged \$0.75 per page for medical records release requests (includes photocopying fees, postage, labor).

---

---

(Print Name)

(Relationship to Patient)

---

(Signature)

(Date)

**Tonawanda Pediatrics 3950 East Robinson Rd., Suite 205 West Amherst, NY 14228, phone: (716) 691-3400, Fax (716) 691-3404**

**Island Pediatrics 2279 Grand Island Boulevard, Grand Island, NY 14072 , phone: (716) 775-3400, Fax (716)**

**775-0455**