Bambini Pediatrics PC

Wholesome Medical Care for Kids

207 Washington Street, Suite 103
Poughkeepsie, NY 12601
Office (845) 249-2510
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HIPPA AUTHORIZATION FORM TO RECEIVE INFORMATION FROM A PREVIOUS DOCTOR

Patient Name: _____ Phone Number**:** _____
Address
City, State, Zip: _____

Email: _____ Date of Birth: MM _____ DD _____ YY _____

Description of information Bambini Pediatrics is to obtain: _____

- Medical Records from date: _____ to: _____
- Entire Medical Record, including patient history, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, and records sent to you by other healthcare providers.
- Other: _____

I authorize BAMBINI PEDIATRICS PC to OBTAIN protected health information from:

Doctor/Group Name: _____

Address:
Street, City & Zip Code: _____

Area Code and Phone Number: _____

Reason for authorization:

- Transferring from another doctor/group
- Returning to Bambini Pediatrics PC
- Other (please explain) _____

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a. This authorization shall be in force and effect for 1 year from the below date at which time it will expire.
b. I have the right to revoke this authorization in writing, except when records have been disclosed in reliance with this authorization.
c. I am signing this authorization freely and under no pressure from any individual to do so.
d. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use. My questions regarding this form have been answered to my satisfaction.
e. This authorization includes disclosure of information relating to ALCOHOL and DRUG ABUSE, and CONDIFENTIAL HIV RELATED INFORMATION, MENTAL HEALTH TREATMENT (except psychotherapy notes) and GENETIC INFORMATION including test results.
f. The recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand I have a right to request a list of people who may receive or use my HIV-related information without authorization.

I hereby declare that I am the patient over 18 years of age, or the natural/adoptive/legal guardian for the person listed above and there is no court order restricting or prohibiting my authorization for Bambini Pediatrics PC to obtain medical records on my behalf:

Signature of Patient or Legal Representative _____ **Date**: _____