Bambini Pediatrics PC

Wholesome Medical Care for Kids

HIPPA AUTHORIZATION FORM
TO RECEIVE INFORMATION FROM A PREVIOUS DOCTOR

Patient Name: _____ Date of Birth: _____
Address (city, state, zip): _____
Phone Number: _____ Email: _____

Information Bambini Pediatrics is to obtain (check one):

- ❑ 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: _____

Bambini Pediatrics PC is to obtain protected health information from:

Doctor / Group: _____ Phone: _____
Address: _____
Reason for authorization:

- ❑ Transferring primary care
- ❑ Consultation / second opinion
- ❑ Other (please explain)

To be read & signed parent (or patient if age 18+):

- I have the right to revoke this authorization in writing, except when records have been disclosed in reliance with this authorization.
- I am signing this authorization freely and under no pressure from any individual to do so.
- 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.
- This authorization includes disclosure of information relating to alcohol and drug abuse, confidential HIV related information, mental health treatment (except psychotherapy notes) and genetic information including test results.
- 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.
- This authorization shall be in force for 1 year from the below date at which time it will expire.

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: _____

4232 Albany Post Road Hyde Park, NY 12538
Voice: 845/ 249-2510 Fax: 845/ 249-2505 Online: www.bambini-peds.com