ELMWOOD PEDIATRIC GROUP, LLP

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please release records to: ELMWOOD PEDIATRIC GROUP

Patient Name: _____ Date of Birth: _____

I authorize disclosure of the above named individual's protected health information as described below.

THIS INFORMATION IS TO BE RELEASED FROM (PREVIOUS PHYSICIAN):

PHYSICIAN / FACILITY NAME: _____

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

PHONE NUMBER: _____ FAX NUMBER: _____

INFORMATION TO BE RELEASED:

_____ **COMPLETE MEDICAL RECORD** (All healthcare information including immunization records, well visits, progress notes, labs, x-rays, growth charts, medications, allergies, specialist reports, hospital notes, etc.)

_____ OTHER (please specify): _____

RELEASE RECORDS TO:

ELMWOOD PEDIATRIC GROUP
919 Westfall Road, Building A, Suite 105
Rochester, NY 14618
Phone: 585-244-9720 Fax: 585-244-9995

For all patients 12 years and older, the patient's signature is required:

_____ _____
Signature of Patient (required for age 12 or over) Date

_____ _____
Signature of Parent/Legal Guardian (required for under age 18) Date

_____ _____
Print Name of Parent/Legal Guardian Relationship to Patient