Steven M. Marsocci, M.D., F.A.A.P.
Marie Lynd Murphy, M.D., F.A.A.P.
William J. Hoeger, M.D., F.A.A.P.
Carolyn T. Cleary, M.D., F.A.A.P.
Myriam F. Bauer, M.D., F.A.A.P.
Mary B. Porter, M.D., F.A.A.P.
Jessica A. Kleinberg, M.D., F.A.A.P.
Sarah E. Hodges, M.D., F.A.A.P.
Ann B. Sorrento, M.S., P.N.P
Sharon C. Harris, M.S., P.N.P

Anne B. Francis, M.D., F.A.A.P., Emeritus

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