Emilia Nymander, M.D., D.O
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.
Claire Wyman, M.D., D.O.
Ann B. Sorrento, M.S., P.N.P

# 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: 585-473-0287

**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



This "Authorization to Release Medical Records" is valid for 1 year from the date signed.