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: 585-473-0283

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.