LEGACY Pediatrics

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please release records to **LEGACY PEDIATRICS**

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:

LEGACY PEDIATRICS
1815 S. Clinton Ave Suite 360
Rochester, NY 14618
Phone: 585-568-8330 Fax: 585-568-8327

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 Date

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