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Fairport, NY 14450
Phone (585) 678-4311
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# MEDICAL RELEASE FORM

Patient Name _____ Date of Birth _____

Address _____ Phone number _____

City/State/Zip _____

Date of request _____

**I authorize Eastside Pediatrics PLLC and:**

_____

(name, address, phone number)

**to release and receive information from each other**.

I understand that:

- My rights to healthcare treatment are not condition on this authorization.
- **I may cancel this authorization at any time by submitting a written request** to the address provided at the top of this from, except where a disclosure has already been made in reliance on my prior authorization
- If the person of facility receiving this information is not a health care of medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV-related information requires additional authorization.

Signature of Patient/Legal Representative _____ Date_____

Print Name of Patient/Legal Representative _____

Relationship to Patient (if requestor is not the patient) _____