650 Whitney Rd, Suite P
Fairport, NY 14450
Phone (585) 678-4311
Fax (585) 678-4332

Medical Release Form

Patient Name____ Date of Birth: ______________________

Address, City, State, Zip____

Phone number: ____________________email address: ____________________Date of Request: ____________

PLEASE CHECK ONE:

____Transferring into Eastside Pediatrics PLLC to see (choose one)
☐ Dr. Cordaro ☐ Dr. Barr ☐ Dr. Cranshaw ☐ Dr. Strang

____Transferring out of Eastside Pediatrics PLLC (where you would like us to send your records)

Name of Provider/Facility: _________________________ Phone: _____________Fax: ________________

Address/City/State/Zip: ____

These records include: (PLEASE CHECK ONE)

____ All medical information available from the last five years. This includes psychiatric history, mental illness history, drug/alcohol use or abuse history, and information including sexually transmitted disease history and treatment, as well as any/all specialist notes.

____ Only medical history from the last five years. This excludes psychiatric history, mental illness history, drug/alcohol use or abuse history, and information including sexually transmitted disease history and treatment.

____ Other ____

I understand that:

- My rights to healthcare treatment are not conditional 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 form, 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 ____

Relationship to Patient (if requestor is not the patient): ____________________________________

revised 8/29/2022