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 , your child's pediatrician will be:
☐ Dr. Joanne Cordaro ☐ Dr. Sudipa Barr ☐ Dr. Wail Tfankji

____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 two 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 two 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): _____