Authorization for the Release of Medical Records

Permission is hereby granted to Suburban Pediatrics for release of information from the medical records of

(patient's name) (birth date)

(street address)

(city, state, zip code)

This information is to be sent to:

(Physician's name)

(street address)

(city, state, zip code)

Information to be released (select one):

( ) complete medical record

( ) dates of service from ____ to ____

( ) records pertaining to ____________

This section must be completed for patients born after May 1, 1996

Authorization for Release of Confidential HIV Related Information

(Human Immunodeficiency Virus that causes AIDS)

Confidential HIV Related Information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV. Since May 1, 1996, all newborn infants in New York State have been tested for HIV prior to their hospital discharge.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.

If you experience discrimination because of the release of HIV related information, you may contact the New York State Division of Human Rights at (212) 961-8624 or the New York City Commission of Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights.

( ) I authorize release of HIV related information for the purposes of maintaining a comprehensive medical record for other health care providers.

( ) I do not give permission for the release of HIV related information.

My questions about this form have been answered. I know that I do not have to allow release of HIV related information and that I can change my mind at any time. I release Suburban Pediatrics from all legal responsibility that may arise from this act. I understand that there is a $0.75 per page charge for this medical records release request (includes photocopying fees, postage, and labor).

Print Name (Parent, Guardian, or Patient (if age of consent)) (Relationship to Patient)

Signature (Witness) (Date)

Suburban Pediatrics 8643 Sheridan Dr., Williamsville, NY 14221
(716) 565-9030 Fax (716) 565-9038

(rev 1.97)