SHERIDAN PEDIATRICS
605 GROVER CLEVELAND HWY
AMHERST, NY 14226-2925
Phone: (716)-836-3300
Fax: (716)-332-1891

RELEASE OF INFORMATION FORM

PATIENT NAME: _____
ADDRESS: _____
_____
_____
DATE OF BIRTH: _____

PLEASE CIRCLE APPROPRIATE BULLET BELOW:

- I hereby authorize Sheridan Pediatrics to RELEASE photocopies of my medical records TO the provider listed below.
- I hereby authorize Sheridan Pediatrics to OBTAIN photocopies of my medical records FROM the provider listed below. You may send these records by CCD/DIRECT if you have MEDENT to (Practice@sheridanpediatrics.medentdirect.com); by fax, via CD, or mail them to our office.

PROVIDER- Physician's Name & Address

_____
_____
_____
_____

- I hereby authorize the office of Sheridan Pediatrics to release photocopies of my medical records to myself. I understand I am receiving these records without a clinical interpretation and should not attempt to draw conclusions from the records without the assistance of my primary physician and I am aware that there will be a charge of $.75 per page (up to 13 pages) or a maximum of $15 to copy my medical records if I choose paper copy.

This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTINAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line. In the event the health information described below includes any of these types of information, and I initial the line on the box, I specifically authorize release of such information to the person(s) indicated.

If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

Specific information to be released:

- Medical Record from (insert date)_____ to (insert date) _____
- Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- Other_____
  _____

Include: (Indicate by Initialing)
_____ **Alcohol /Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

This consent will expire one year after the signed date below. I may revoke this authorization at any time providing I notify Sheridan Pediatrics in writing to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization is considered acceptable in lieu of the original. I hereby indemnify Sheridan Pediatrics against all legal responsibility of liability that would be caused by the action of releasing my records as authorized above.

_____ _____
Patient Signature Date

_____ _____
Patient/Legally Authorized Rep. Relationship to Patient