☐ Lockport Pediatrics
38 Heritage Court
P.O. Box 498
Lockport, NY 14095
(716) 433-4427
Fax (716) 433-8804

☐ Niagara Falls Pediatrics
750 Portage Road
Niagara Falls, NY 14301
(716) 282-1223
Fax # (716) 282-1235

Pediatrics Authorization Form for Release of Health Information

Patient Name________________________________ Patient DOB____________ ID#____________

Parent/Legal Guardian Name______________________________ Relationship______________________

Address____ Phone#__________________________

I am the parent or legal guardian of above named patient (or patient if age 18 or over). I do hereby authorize Planned Parenthood of WNY to furnish records to:

Name of Provider ____

Address ____

Phone#_______________________________________ Fax#______________________________________

Health Information to be released/obtained includes immunization records, lab reports, radiology reports, and record of provider visits.

Conditions of Authorization
1.) This authorization will expire on (enter date) ____.
2.) I understand that this authorization is voluntary and may be revoked at any time by notifying Planned Parenthood of Western New York in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of Western New York has already acted upon such authorization.
3.) I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except for certain types of information otherwise protected by federal and/or state law or regulation)..
4.) By authorizing this release of information, my healthcare, and payment for my healthcare will not be affected if I do not sign this Authorization form.
5.) I have been offered a copy of this signed Authorization form.

This authorization is made for the following purpose:

- Closure of the pediatric practice of Planned Parenthood of Western New York.

Signature of Parent/Guardian ____________________________________ Date_______________________

Signature of Witness ____ Date _______________________