



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

Niagara Falls Pediatrics
732 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 or Obtain records for the purpose of continuity of care.

Name of Provider _____

Address _____

Phone# _____ Fax# _____

- Health Information to be released/obtained:
- Summary of care _____
 - Immunization records _____ Lab/X-ray reports _____
 - Newborn Screening _____ Other _____
 - Birth records (Newborn discharge summary including HepB vaccine documentation)

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.
- 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:

- At my request, OR
- Specify: _____

Signature of Parent/Guardian _____ Date _____

Signature of Witness _____ Date _____