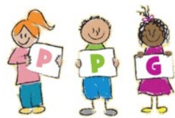

PANORAMA
PEDIATRIC GROUP

220 Linden Oaks Suite 200 • Rochester, NY 14625
Phone 585.381.4848 | Fax 585.641.2205

Authorization to Release Medical Records

Patient Name:________________________________ **Date of Birth**_______________ **Phone #**___________________

Purpose of Request/Disclosure (Select one):

- ☐ Transferring to another physician (Indicate reason)
  - ☐ Transferring to Internist due to age
  - ☐ Insurance Issue
  - ☐ Moving: New Address:____
  - ☐ Other (please specify):____
- ☐ Referral to specialist
- ☐ New patient of Panorama Pediatric Group
- ☐ Other:_____________________________

I authorize Panorama Pediatric Group to (Select one)**:**

- ☐ **SEND** my medical records to:
- ☐ **OBTAIN** my medical records from:

Physician's Name:__________________________Phone #:_________________Fax #: _________________
Practice Name:____
Address:______________________________________ State: ________________ Zip: _________________

Method of Delivery (please allow us up to 10 business days to complete your request):

- ☐ Please mail records to:

Name:________________________Address: ____
Town, State, Zip: _______________________________________Phone #: ___________________________

- ☐ I will pick up records when they are ready.

Name: ____ Phone #: ___________________________
(Photo ID is required when picking up records)

I authorize Panorama Pediatric Group, RLLP to disclose the following protected health information *(select 1)*

- ☐ **Recommended - Medical Record Summary** including immunizations, growth charts, allergies, medications, problem list, past medical, family, and social history, and the last 3 years of office visits, physicals, labs, x-rays, and specialist reports (may include information relating to mental health, alcohol/drug treatment and/or confidential HIV/ AIDS information)
- ☐ Complete Medical Record (may include information relating to mental health, alcohol/drug treatment and/or confidential HIV/AIDS information)
- ☐ Complete Medical Record with the following exceptions (please specify): _______________________________________
- ☐ Other (please specify): ____

FOR ALL PATIENTS 12 YEARS AND OLDER, THE PATIENT'S SIGNATURE IS REQUIRED:

____ ____________________________
Signature of Patient (required for age 12 or over) Date

____ ____________________________
Signature of Parent/Legal Guardian (required for under age 18) Date

____ ____________________________
Print Name of Parent/Legal Guardian Relationship to Patient

Expiration Date: This authorization will expire 1 year after the date signed or until the following event/date________________________.
PPG policy is to provide one copy of the medical record at no charge when our patients transfer to another physician. The cost for copies requested for other purposes, or for additional copies, will be $0.75 per page, as described in NY Public Health Law §17.