# KINDCARE PEDIATRIC CENTER

63 Central Avenue, Passaic , NJ 07055

Tel: (973) 574-8688 Fax: (973) 249-8799

## AUTHORIZATION FOR RELEASE OF PATIENT RECORD & INFORMATION

I _____ born on _____ do hereby consent and authorize

(**Name of Patient**) (**Date of Birth**)

the following institution:

**Name of Physician / Hospital or ( ) NJ Newborn Screening**:_____

Address:_____

Phone Number: _____

Fax Number:_____

To disclose to : ( ) **Kindcare Pediatric Center** or ( ) other:_____

And the purpose of this disclosure is for continum of care, please include the following :

( ) lab results/ screenings ( ) significant medical history ( ) vaccine record ( ) consult reports ( ) medication history

( ) ER or hospital admission information for date/s:_____

( ) Radiology reports ( ) for date/s:_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this Authorization, I must do so in writing and present my written revocation to the Privacy Office at Kindcare Pediatric Center. I understand that the revocation will not apply to information that has already been released to this Authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy,

Unless otherwise revoked, this Authorization will expire on the following date, event, o condition or in one year:_____

Today's Date:_____

Patient's Signature:_____

Parent/Legal Guardian or Authorized:_____

Witness to Signature(s): _____

Name of person, other than requestor, picking up copy of medical record:_____

Children over 18 years of age must request their own records.

If it is determined by the office that your records ar protected by Federal or State law and regulations concerning confidentiality or alcohol and drug abuse patient records, the diagnosis and treatment of AIDS, HIV infection or HIV related illness; the following note will be attached to the information sent to the recipient. If you fail to specify an expiration date, event or condition, this authorization will expire in 1 year.

Note to Recipient of information: This information has been disclosed to you from records protected by Federal or State confidentiality rules (42 CF 2.1 ct seq: or N.J.S. A26:5=1ct Seq) Federal o State rules prohibit you from making any further diclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR & ct seq, or N.J.S.A :c-1 ct seq. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal or State rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.