MAIN STREET PEDIATRICS

Robert D. Basow, M.D., F.A.A.P.
Stephanie Bodor, M.D., F.A.A.P.
Claire Y. Price, M.D., F.A.A.P.
Katherine Pleet, M.D.
Donna Joshi, C.P.N.P.
Erica Holleran, C.P.N.P.
Christine Lattuada, C.P.N.P.
Faith Decesare, C.P.N.P.
Carrie M. Davies, M.D., F.A.A.P.
Marissa Ford, L.I.C.S.W.
Gretchen Golz, L.I.C.S.W.
Charlotte Delaney, M.D.

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

(PHI - Protected Health Information)

There will be a $10.00 per patient processing fee ($40.00 maximum per family).
Under the privacy rule, medical practices may charge patients a fee for copying records.

Patient Name:_____ Date of Birth:_____

Address: _____ Phone #: _____

City, State, and Zip:_____

Main Street Pediatrics is authorized to disclose medical records

Please Send Medical Records to:
Home/Physician/Clinic: _____

Street Address: _____

City, State and Zip: _____

Reason for leaving Main Street Pediatrics: _____

I hereby authorize release of this record to include information related to:

- ☐ Alcohol/Drug Use or Treatment
- ☐ Treatment for Behavioral Health Illness
- ☐ Treatment for Sexually Transmitted Illness/Venereal Disease
- ☐ Treatment of HIV/AIDS

I understand that I have the right to revoke this authorization at any time and it must be done by submitting a written request to the office manager at Main Street Pediatrics. I understand that the revocation will not apply to information that has already been released. I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Parent/Legal Guardian Signature/ 18+ Adult Signature: _____:

Print Name of Parent/Legal Guardian/18+ Adult: _____

Relationship to Patient: _____ Date: _____