HEIGHTS PEDIATRICS

50 CLARK STREET
BROOKLYN, NY 11201
TEL.: 718-858-4924
FAX: 718-522-4954

WWW.HEIGHTSPEDIATRICS.COM

Request Medical Record Release Authorization Form

This form is used to request records from the following doctor or hospital

Doctor or Hospital Name : _____

Address : _____

Phone: _____ Fax: _____

Please send Heights Pediatrics the complete history of records in your possession concerning my child(ren)'s illness/and/or treatments during the period:

From: ____ / ____ / _____ To: ____ / ____ / _____

Name of Patient(s): _____

Date of Birth: _____ Phone: _____

Patient's Address: _____

Purpose of Request: _____

Authorization Expiration Date: ____ / ____ / _____

By signing, I hereby authorize the release of my medical records to:

Heights Pediatrics
Katerina Silverblatt, MD / Maria Beatriz Maidana Moreno, MD / Sara Batool, DO / Erika Podias, APRN
50 Clark St, Brooklyn, NY, 11201
P: 718-858-4925 F: 718-522-4954

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. I understand that once my medical records are disclosed, they may no longer be protected by federal privacy regulations. I understand and acknowledge that the release of medical records is voluntary and that the treatment, payment, or eligibility for benefits and services may be conditioned upon obtaining my/our authorization to release these records. I further understand that the information disclosed may include sensitive medical and/or mental health information.

Parent/Guardian Full Name (Print): _____ Relationship to Patient: _____

Parent/Guardian Signature:_____ Date: ____ / ____ / _____

This authorization form has been reviewed, and the release of medical records has been authorized in accordance with applicable HIPAA regulations.

Staff Witness: _____