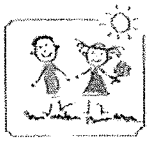

Plattsburgh Primary Care Pediatrics

Primary Care Health Partners - New York, LLP

PCP:

Name:

DOB:

Patient #:

Method of Payment:

Patient Information

Authorization for Release/Request of Information

Method of Disclosure: ☐ Pick-up ☐ Fax ☐ Mail ☐ Obtain records from

_____

Name

_____

Address

_____

Phone Number

☐ Full Chart ($10 fee; Disc)
☐ Physical form ($5 fee)
☐ Attorney request
☐ Minimum Information
☐ Immunization Record ($5 fee)
☐ Other:_____

Covering the period from _____ to _____

Date Date

For the following reason (check all that apply):

☐ Transferred
☐ Discharged
☐ Aged out
☐ Leaving the area
☐ Dissatisfaction with office or care
☐ Other:_____

Signature _____ Date _____

(of patient, parent or legal guardian, if patient is a minor)

Authorization is valid for one year, unless revoked by the patient.

Please return this form to Medical Records

Staff: Request completed -Initials & Date