Trinity Pediatrics

Medical Records Release Authorization

Patient Name/s	Date of Birth

Previous Provider/Practice Name & Address

- ☐ Immunization records, Growth Charts, Problem List
- ☐ All records
- ☐ Other (please specify): _____

Reason for requested disclosure: To transfer or facilitate the medical care of the individual(s) listed above.

The personal health information is to be disclosed to:

Trinity Pediatrics
Gloria M Roetzer, MD
2730 Union Road
Cheektowaga, NY 14227
Ph: 716-332-7377 fax: 888-452-3065

Please read and sign. I understand the following:

1. I authorize the release of personal health information to Trinity Pediatrics
2. I may revoke the authorization at any time by providing written notice to the practice.
3. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.
4. The practice will not condition treatment or payment based on my signing authorization.
5. I am signing this authorization freely; no one has pressured or coerced me to sign this authorization.
6. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer be protected by federal law.
7. I acknowledge that I had an opportunity to review this authorization and the intent and the use.
8. I understand that I am entitled to a copy of this authorization, at the time of its execution. If so, I will make my request known.

_____ _____ _____

Parent/Legal Guardian Signature Relationship to Patient Date