**ALLENTOWN PEDIATRIC & ADOLESCENT MEDICINE, LLP**

**INDIVIDUAL AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient's Name: ______________________________ Date of Birth: ____________________

I hereby authorize: **(PLEASE ENTER YOUR PREVIOUS DOCTOR'S NAME AND ADDRESS)**

Doctor/Office Name:____________________________________________________________

Address:_______________________________________________________________________

City-State-Zip code:___________________________________________________________

Office Phone:__________________________________________________________________

## To release ALL my child's medical records including immunizations to:

**Allentown Pediatric & Adolescent Medicine, LLP**
**560 Franklin Street**
**Buffalo, NY 14202**
**Office: 716-332-4472 Fax: 716-332-4474**

Please also include any of the following information if applicable (Check all that may apply):

_______HIV information _______Chemical Dependency records _______Mental health records

We understand that information about you and your health is personal and we are committed to protecting the privacy of that information. We must obtain written authorization before we may use or share your health information for the purposes other than releasing your information to insurance companies for the purpose of reimbursement or to another physician that Allentown Pediatric & Adolescent Medicine may refer you for specialty care. By signing this authorization, you acknowledge your understanding of how your protected health information will be used and/or shared and that all your questions relating to this form have been answered prior to signing it.

_______________________________________________________________________________

Printed Name of Authorizing Person Date

_______________________________________________________________________________

Signature Relationship to patient if a minor

Revised 1/2024