Lewiston Village Pediatrics

Shawn P. Ferguson, M.D., FAAP
Donna L. Poirier, FNP
Melanie A. Leberman, PA-C

733 Center Street
Lewiston, NY 14092
Phone: 716 754-7337
Fax 716 754-2041

Authorization for Release of Medical Information

Patient's Name: _____ **Date of Birth:** _____

□ I authorize Lewiston Village Pediatrics **to release information to:**

_____
Name of Provider or Facility

_____
City, State, Zip Code Phone/Fax #

OR

□ I authorize Lewiston Village Pediatrics, **to obtain information from:**

_____
Name of Provider or Facility

_____
City, State, Zip Code Phone/Fax #

PURPOSE FOR THIS REQUEST: (Check one) □ School/Daycare/WIC/Camp/Administer Medication
□ Personal □ Other: _____

TYPE OF RECORDS REQUESTED: (Check one)
□ Immunization Records □ Physical History Form and/or Immunization Records
□ Specific Information: _____

AUTHORIZATION VALID FOR: _____
(Expiration Date)

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medial insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- There may be a charge for the requested records.

Signature of Patient or Legal Guardian: _____ **Date:** _____

Relationship to Patient: _____

Lewiston Village
Pediatrics