DJAFARI PEDIATRICS
15-17 KENNEDY PARKWAY
CORTLAND, NY 13045
607-753-3051, FAX# 607-753-7735

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____

Is the Patient a minor? Yes_____No_____ Date of Birth_____

Patient Home Address:_____

Patient Home Phone#_____

I authorize Djafari Pediatrics to RELEASE information contained in the medical record:
TO: NAME_____**FROM**: NAME_____
ADDRESS:_____ADDRESS:_____
CITY,ST,ZIP_____CITY,ST,ZIP_____
PHONE:_____FAX:_____PHONE:_____FAX:_____

For the visit dates of _____

The purpose of providing this information is:

_____Transfer of Medical Care
_____Referral for Medical Care
_____Life Insurance Application
_____Health Status Report
_____Other_____
_____Workers compensation
_____No Fault
_____Disability
_____Immunizations

In copying my medical records, if the following information is mentioned, it should be released.
Y___N___HIV related information (AIDS related testing)
Y___N___Substance abuse (including alcohol/drug abuse)
Y___N___Mental health (including psychotherapy notes)

UNLESS OTHERWISED INDICATED, THIS AUTHORIZATION WILL EXPIRE IN 1 YEAR FROM DATE

*I understand that I may revoke this authorization at any time by notifying the provider in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

***I understand that there may be a processing fee required for transfer of records. Please inquire.

Signature_____Date_____

Relationship to Patient_____

Witness_____Date_____

02/2017