



Pediatric Cardiology Associates of WNY, LLC
936 Delaware Avenue, Suite 100
Buffalo, NY 14209
(716) 885-KIDS

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **DOB:** _____

I, _____, hereby authorize
(Guardian or patient)

Pediatric Cardiology Associates permission to release medical information on the name of
the patient above to: _____

(Name and address of doctor's office or facility)

Description of the information to be used or disclosed (check all that apply):

___ The patient's entire medical record.

___ The patient's demographic information __Name__ Age__ Address__ Gender __
__State/Zip Code__ Race__ Telephone__ Other

___ Medical Data/Information as related to: Specific conditions _____
Specific medications _____ Specific testing _____

___ Other: _____

I understand Pediatric Cardiology Associates of WNY, LCC is authorized by me to use or disclose the above named patient's protected health information for a purpose of treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke the authorization.

Patient or Responsible Party's Signature

Date

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective Pediatric Cardiology Associates of WNY, L.L.C. must receive the revocation in writing including patients name, address, and effective date of revocation.