Boston Children's Health Physicians
Until every child is well™ formerly CWPW

AUTHORIZATION for the Release of Medical Information

Patient Name:	Phone Number:
Patient Address: Street, City, State, Zip	
Date of Birth: MM DD YY	

I hereby authorize Name of Practice and Physician: _____ [health care provider] to disclose or transfer my protected health information as indicated below.
Address: _____

FAX: _____ PHONE: _____

This information is to be disclosed to:
FAX: (845) 986-7669 PHONE: (845) 986-2058

Name: Attention of: **HERBERT KANIA PEDIATRICS**

Street Address: **10 RONALD REGAN BLVD**

City, State, Zip: **WARWICK, NY 10990**

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

For dates of treatment from _____ to _____

REASON FOR REQUESTED USE OR DISCLOSURE:
[ ] Transfer of health coverage [ ] Personal use [ ] Form completion [ ] Referral

[ ] Change in health care provider [ ]Other

This authorization expires in one year from the date signed or earlier _____
Date

TO BE READ AND SIGNED BY PATIENT:

I understand the following:
a. I may revoke this authorization at any time by providing written notice to the practice.
b. 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
c. The disclosing provider will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure form any individual to do so.
e. The information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA or other privacy laws.
f. I acknowledge that I have had an opportunity to review this authorization and understand its intent and use.
g. I will receive a copy of this completed and signed authorization form.

There will be a charge of 75 cents per page for copying medical records plus cost of mailing.

Patient Signature:	Date:

Herbert Kania Pediatric Group
Boston Children's Health Physicians
Until every child is well

10 Ronald Reagan Boulevard Warwick, New York 10990
(845) 986-2058 Fax (845) 986-7669

Jeffrey S. Horowitz, M.D., F.A.A.P.
Maria J. Sharma, M.D., F.A.A.P.
Elissa Kappel, FNP-BC

MINOR CONSENT

For Children Under Age 18

I authorize my child _____, Date of Birth _____ to be seen on

_____ (date) by Herbert Kania Pediatric Group.

1. **Alone or Accompanied to Appointment:**
   - My child may be seen without being accompanied by anyone.
   - My child may be seen only accompanied by _____ and BCHP personnel.
2. **Alone or Accompanied in Examination Room:**
   - My child may be seen and treated in the examination room without being accompanied by anyone.
   - My child may be seen and treated in the examination room only accompanied by _____ and BCHP personnel.
   - I authorize any test or procedure to be done on my child in the course of treatment.
   - I authorize vaccines to be administered during this visit. _____ (Initial)

     _____ _____ _____ _____ _____

     (Authorized Vaccines to be given)
3. This authorization is valid for the following date or period of time _____.

Parent/Guardian Signature _____

Print Name _____

Date _____

FOR VERBAL CONSENT OBTAIN ANSWERS TO #1, 2, AND 3 ABOVE

Date _____

Verbal consent obtained by phone call at: _____
Phone number received from / called & time of call

_____
Name of person giving verbal consent & relationship to patient

Witnessed by: _____