TRIBECA PEDIATRICS

We care for your kids

- TRIBECA
- CHELSEA
- UPPER EAST SIDE
- LOWER EAST SIDE
- EAST VILLAGE
- HARLEM
- WILLIAMSBURG
- BOERUM HILL
- PARK SLOPE
- FORT GREENE
- BAY RIDGE
- DITMAS PARK
- PROSPECT HEIGHTS
- GREENPOINT
- LONG ISLAND CITY
- JERSEY CITY
- SILVERLAKE

Authorization For Release of Medical Records

To Previous Physician / Practice / Hospital:

Please release the complete medical records of my child/children to:

Tribeca Pediatrics
11 Park Place
Suite 1200
New York, NY 10007

Name of Child/ Children:

Date of Birth:

Date of Birth:

Date of Birth:

"I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:
All medical records, meaning every page in my record, including but not limited to: Office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic record, treatment plans, admission records, discharge summaries, request for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and record received by other medical providers."

Signature of Parent/Guardian Authorizing Release:

Relationship to child/children:

Date:

*If you'd like a copy of the records returned to you, please include a self addressed manila envelope with your child's records.

For Newborn Screening Only

First and Last Name of Birth Mother

Date of Birth:

P: 212-226-7666 | F: 212-202-7988 | info@tribecapediatrics.com