Mark Klier, MD
4415 Buffalo Road, Suite 1B
N. Chili, NY 14514
Phone # (585)594-9200, Fax # (585)594-9233

Records Release Form

Patients Name______________________________, Date of Birth____________

I authorize Dr. Klier, of Ogden Pediatrics to transfer my medical records to:

Name and address: ____

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Reason for record release____

Please note: all records will be sent **except** those containing information regarding HIV, Alcohol/Drug or Mental Health issues (unless we are authorized by law to forward this information on). If you would like this information included, please specify what you would like sent and sign on the appropriate line. Selected items to include:

Please send medical records regarding HIV information
(signature)____________________________________(*A separate form is required for release of this documentation. Please request a form from this office).*

Please send medical records regarding Alcohol/Drug information
(signature)____________________________________

Please send medical records regarding ADHD/ADD and Mental Health information
(signature)____________________________________

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______________________________ ______________________________
Signature of Parent / **Patient (if 18 yrs. or older)** Date

______________________________ ______________________________
Printed Name of Parent / **Patient (if 18 yrs. or older)** Relationship to Patient

______________________ ______________________ ____________
Witness Printed Name Signature Date