

**PINE STREET PEDIATRIC ASSOCIATES, PC**

Donald Z. Rosenblum M.D., F.A.A.P.  
Jane H. Ferguson, M.D., F.A.A.P.  
Joseph Appel, M.D., F.A.A.P.  
Roger D. Green, M.D., F.A.A.P.  
Valerie M. Sprenz, M.D., F.A.A.P.  
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Peter J. O'Connor, M.D. F.A.A.P.  
Danielle Cigliano, D.O., F.A.A.P.  
Maria T. Brown, M.S., C.P.N.P.  
M. Scott Owitz, M.S., F.N.P.-C

**Authorization For Release Of Medical Records**

I, \_\_\_\_\_, hereby authorize and give permission to:

\_\_\_\_\_  
(Name / address / fax of office which records are to be released from )

\_\_\_\_\_  
\_\_\_\_\_

To release medical information regarding:

Patient's Name:

Date of Birth:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please Print Legibly

I have read and understand the following: I hereby authorize the release of medical records including psychiatric, drug/alcohol abuse and HIV information, if applicable. I understand that the information is confidential and protected from disclosure.

I request that this information be released only to Pine Street Pediatric Associates, PC. This information is to be released only for the purpose of establishing care. This authorization to release medical information may be revoked by myself, in writing at anytime, except to the extent that this information has already been released.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Please circle which office to mail records to:

Pine Street Pediatric Associates, PC

140 Pine Street, Suite 210 Kingston, NY 12401 Tel: 845-331-4484 Fax: 845-331-7160	8 Prince Street Red Hook, NY 12571 Tel: 845-758-1996 Fax: 845-758-8462	145 Sawkill Road Kingston, NY 12401 Tel: 845-340-1760 Fax: 845-340-9258	550 Route 299, Suite 200 Highland, N.Y. 12528 Tel: 845-883-4400 Fax: 845-883-4406
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