



Eastchester Pediatric Medical Group
 CHILDREN'S AND WOMEN'S PHYSICIAN'S of WESTCHESTER, LLP

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PATIENT RELEASE OF RECORD

Patient name _____ Date of Birth _____

I am transferring my care/child's care to another physician/practice.

I would like to obtain a copy of my protected health information records from Eastchester Pediatric Medical Group.

Delivery	
<input type="checkbox"/>	I would pick up the copy of my records at the following date and time:
<input type="checkbox"/>	Please mail/fax me the copy of my records to
PHYSICIAN/GROUP	_____
ADDRESS	_____

PHONE	() _____
FAX	() _____

The practice has the right to deny access, in whole or in part, to protected health information as provided in § 164 524 paragraph (a) sections (2) and (3) of the Healthcare Portability and Accountability Act of 1996

Signature _____ Date _____

Relationship to patient (if signed by a personal representative of patient) _____