



CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____ Account: _____

1. I hereby request and authorize **OB/GYN Care of WNY** to:

Release Information **TO:** _____ Obtain Information **FROM:** _____
ONLY LIST ONE PROVIDER/FACILITY PER RECORD RELEASE

2. Name of Provider/Facility: _____
Address: _____
Telephone: _____ Fax: _____

3. The **PURPOSE** of this release is: (check all that apply)
 Moving Insurance Purpose Transferring Care Second Opinion
 Personal Review Other (please specify) _____

4. The **FOLLOWING** Protected Health Information (PHI) may be released: (**please check one**)

I consent to the release of **all medical records** including records, reports or tests concerning alcoholism and/or drug abuse or treatment information, sexually transmitted disease related and/or psychological or psychiatric treatment. I also understand that the release of information related to the diagnosis or treatment of HIV requires an additional authorization. (This release excludes any records transferred to OB/GYN Associates from previous care providers.)

I consent to the release of **all medical records** with the following exceptions: (Specifically describe the information you do not wish to have released) _____

I consent to the release of **all medical records** relating to the following treatment or condition: _____

I consent to the release of **all medical records** from _____ to _____
Date Date

5. **This authorization will automatically expire within one year from the date of signature, unless otherwise specified.** I understand that I have the right to revoke this authorization in writing at any time, except where information has already been released in response to this authorization. **Expiration:** _____
Notice to Patient: NYS Public Health Law Chapter 45, L1991, C165 Section 58 allows us to charge for copies of records. Our policy is to charge a fee of \$.75 per page for copying and administrative costs. This fee will not be charged unless the copying cost exceeds \$3.00 and will not exceed a total charge of \$25.00.

Signature of Patient or Legal Guardian

Date

*Patients ages 12 and up must sign the release themselves

Relationship to Patient