Patient Authorization of Release/ Disclosure of Health Information

RECIPIENT OF HEALTH INFORMATION

My doctor has provided this HIPAA compliant request/authorization form in order to assist me in requesting you to forward copies of my medical record. By signing this authorization, I request and authorize you to release certain protected health infromation (PHI) about me to:

MEDICAL PRACTICE: Inspired Health Group, 3671 Southwestern Blvd, Suite 101, Orchard Park, NY 14127

DIRECT MESSAGE ADDRESS: RErickson@familypractice.medentdirect.com

MEDICAL RECORDS FAX: 716-508-8073 **PHONE NUMBER:** 716-662-7008

SENDER OF HEALTH INFORMATION

MEDICAL PRACTICE: _____

(NAME & ADDRESS) _____

_____

_____ **PHONE NUMBER**

_____ **MEDICAL RECORDS FAX**

DIRECT MESSAGE ADDRESS OF PERSON(S) OR CATEGORY OF PERSON OF WHOM WILL SEND THIS INFORMATION: _____

SPECIFIC INFORMATION TO BE RELEASED

- ☐ Medical information from/to date: _____
- ☐ Entire medical record, including: patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, and records sent to you by other health care providers
- ☐ Other: Last year's progress notes, labs, consults and imaging, last mammogram, PAP, DEXA and colonoscopy, immunization and medication list
- ☐ _____

INCLUDE: Indicate by initialing. The following information will not be released unless you specifically request by intially the iteam

- ☐ Chemical dependency records (related to alcohol or substance abuse or treatmet) **INITIAL** _____
- ☐ Mental Health Information (includng care for anxiety and depression) **INITIAL** _____
- ☐ HIV Related Information (signed NYS form 2557 required) **INITIAL** _____

- The information will be used or disclosed for the following purpose: Further medical care
- This authorization will expire in 90 days. This disclosure can be revoked at your request.
- When your information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that your office acted in reliance upon this authorization. My written revocation must be submitted to your Privacy Officer at the address listed above

NAME OF PATIENT: _____ **DATE OF BIRTH:** _____

PATIENT'S ADDRESS : _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ **RELATIONSHIP TO PATIENT:** _____

PRINT NAME OF PATIENT OR LEGAL REPRESENTATIVE: _____ **DATE:** _____