

MEDICAL RECORDS AUTHORIZATION

I HEREBY AUTHORIZE: _____
(i.e. Doctor, Hospital)

to disclose the following protected health information: (Specifically describe the information to be released. This office will NOT respond to a request that simply says "All records"): _____

RELEASE RECORDS TO:

Name: _____

Address: _____

Fax #: _____

Disclosure of information is authorized for the following purposes: _____

I UNDERSTAND that I may refuse to sign this authorization. My refusal does not affect my treatment. I may revoke this authorization at any time, in writing, and that if I choose to do so, my request to revoke will not affect any actions taken by the Buffalo Otolaryngology Group before receiving my revocation.

I UNDERSTAND that there is a potential for information use or disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected by federal or state law.

THE EXPIRATION DATE cannot be greater than 90 days from the date of the request.

I fully understand and accept the terms of this authorization.

PATIENT'S NAME: _____
(Please print - If name was different due to marital status, please include previous name as well)

Patient's Address: _____

Relationship: _____

Birthdate: ____/____/____

Signed: _____

Date: ____/____/____