Ryan Buffington, MD ● Kristine Buffington, PsyD ● Allison DiMaggio, PA-C ● Kaylee Davis, PA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO BUFFINGTON FAMILY MEDICINE

Medical information is generally not released to others without your consent. Do not sign this release form unless it is filled out completely and you believe that the release of this information is in your best interests.

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ Phone: (_____) _____-_____

I do hereby authorize Buffington Family Medicine *to request and receive information from*:

Name: _____

Address: _____

Phone/Fax: _____

E-Mail: _____

Information may include, but is not limited to: professional opinions, reports or examinations, tests, treatment, diagnosis, and prognosis.

I understand that I may revoke my authorization at any time by providing a written request for such, except as to actions that have been taken in reliance upon it. I understand this form may serve as consent for my counselor and my medical provider at Buffington Family Medicine. I also understand that a photocopy of this authorization may serve as an original.

Signed: _____ Date: _____