Northeast Medical,P.C.

□ 2865 Genesee Street | Cheektowaga, NY 14225
Phone: 716-262-0616 | Fax: 716-262-0631
www.northeastmedicalpc.com

□ 3488 Sheridan Drive| Amherst, NY| 14226
Phone: 716-832-6207 | Fax: 716-832-3282

Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

PLEASE CHECK ONE:

I request and authorize Northeast Medical, P.C. to: □ **Release to** □ **Obtain from**

Name: _____

Address: _____

City:_____State:_____ Zip Code:_____

Telephone: _____ Fax: _____

You may use or disclose the following health care information (check all that apply)

Patients records may be faxed free of cost, depending on the size of the chart. If paper copies are requested, there will be additional charges. All payments are required prior to copying.

□ Chart notes □Patient Visit Summary □ All Records
□ Labs / Pathology □ Most Recent Visit □ X-rays / Diagnostics □ Billing
□ Other _____
Time Frame Requested _____ This authorization is valid until: _____
Date

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this authorization. I have authorized NORTHEAST MEDICAL, P.C. to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original.

Specific Authorization:

I understand that I may revoke this authorization in writing at any time to NORTHEAST MEDICAL, P.C., except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months unless otherwise dated above. Signature/Legally Responsible Party Relationship to Patient Date I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information unless I have marked NO and initialed it. _____ YES _____ NO _____ INITIALS _____

_____ _____ _____
Signature/Legally Responsible Party Relationship to Patient Date