



Patient request/authorization to release/obtain patient health information

Information released from

Information release to

Name of clinic/hospital	Name
Address	Address
City	city
State zip	State zip

Patient name _____ Birthdate _____

Type of information to be released

- | | | |
|---|--|---|
| <input type="checkbox"/> Clinic office notes | <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Cardiac |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Radiology reports | <input type="checkbox"/> OB/Gyn |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Radiology films/CD | <input type="checkbox"/> Surgical reports |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Urgent care reports | <input type="checkbox"/> All records |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> HIV/AIDS/STD's | <input type="checkbox"/> Chemical/Alcohol Use/Abuse |
| <input type="checkbox"/> Other _____ Specific dates _____ | | |

Reason for Disclosure

Continuing care Insurance Attorney Personal Other

I understand that

- That by signing this form I am authorizing the release of my protected health information.
- I may revoke this authorization at any time with written notification but it will not affect information that has already been released.
- There may be a fee for information and that I may be responsible for that fee.
- That this release will expire 1 year from date of signature.
- Information going to a health care provider or plan covered by federal privacy laws will be protected by federal privacy laws.
- Information received at other facilities may not be protected and may be re-disclosed by that facility.
- Buffalo/Monticello Clinic does not routinely release information from other facilities.

Signature of patient/parent/guardian

Date

Relationship to patient

Signature of Witness

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