

**CHURCHVILLE-CHILI FAMILY MEDICINE LLC  
4201 BUFFALO ROAD, PO BOX 505  
N. CHILI, NY 14514  
(585)594-5995**

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Date of request: \_\_\_\_\_ Date needed: \_\_\_\_\_

<input type="checkbox"/> I authorize Churchville-Chili Family Medicine to <b>OBTAIN</b> information from:  _____ <b>Name of provider, facility, or other person</b>  _____ <b>Address</b>  _____ <b>City, State, Zip Code</b>  _____ / _____ <b>Phone/Fax number (include area code)</b>	<input type="checkbox"/> I authorize Churchville-Chili Family Medicine to <b>RELEASE</b> information to:  _____ <b>Name of provider, facility, or other person</b>  _____ <b>Address</b>  _____ <b>City, State, Zip</b>  _____ / _____ <b>Phone/Fax number (include area code)</b>
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Purpose for this request: Changing physicians  Insurance Coverage  Personal  Other   
 Type of records requested:

Treatment summary (includes history/physical, laboratory tests & reports, pathology)

Entire copy of patient record (**NOTICE: This would include ALL sensitive information in your chart such as any HIV related information, mental health related care, substance abuse diagnosis and treatment, etc.**)

All medical records related to a specific illness or injury: \_\_\_\_\_

Specific timeframe: Dates from: \_\_\_\_\_ to \_\_\_\_\_

AUTHORIZATION VALID FOR:

This request only  One year from the date of this authorization. (This authorization applies to the records of the treatment received on or prior to the date of this authorization.)

I understand that:  
 -My right to healthcare treatment is not conditioned on this authorization.  
 -There may be a charge for records requested from Churchville-Chili Family Medicine.  
 -I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.  
 -If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information in your record requested above could be disclosed.  
 -Requests for complete records will include any sensitive information contained therein, such as HIV-related information, substance abuse diagnosis and treatment, mental health related care, etc.

Signature of Patient or Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient (if requester is not the patient): \_\_\_\_\_

**HIPAA Authorization**

Without a HIPAA Authorization we are unable to discuss any information pertaining to your health with anyone other than those legally mandated (for example, other doctors as needed for continuity of medical care, insurance companies or legal entities). Aside from those legally mandated, you must specify precisely who you permit our office to discuss your information with. **This is to protect your privacy.**

\_\_\_\_\_

Patient Name: \_\_\_\_\_

I hereby authorize the following individual(s) to discuss my Personal Health Information as indicated below

My Spouse \_\_\_\_\_  Other Name \_\_\_\_\_

Address: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Signature of Patient or Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Print Patient /Representative Name: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ I do not authorize any release of or access to my personal health information

\_\_\_\_ I specifically do not authorize \_\_\_\_\_ to discuss my personal health information

Signature of Patient or Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Print Patient /Representative Name: \_\_\_\_\_