

**CHURCHVILLE-CHILI FAMILY MEDICINE LLC
 4201 BUFFALO ROAD, PO BOX 505
 N. CHILI, NY 14514
 (585)594-5995
 FAX (585)594-5425**

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 OBTAIN information from: _____ Name of provider, facility, or other person _____ Address _____ City, State, Zip Code _____ / _____ Phone/Fax number (include area code)	<input type="checkbox"/> I authorize Churchville-Chili Family Medicine to RELEASE information to: _____ Name of provider, facility, or other person _____ Address _____ City, State, Zip _____ / _____ Phone/Fax number (include area code)
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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 for, 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: _____