

Authorization for Release of Protected Health Information

From Highgate Medical Group

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

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I Authorize release of my protected health information

From:

Name- \_\_\_\_\_

Address: \_\_\_\_\_

Phone- \_\_\_\_\_

Fax- \_\_\_\_\_

To:

Name - Highgate Medical Group \_\_\_\_\_

Address - 1150 Youngs Rd., Suite 104

Williamsville, NY 14221

Phone - 716-636-7979

Fax - 716-636-7993/716-929-0192

I would prefer the following information be disclosed: (Please check all that apply)

\_\_\_\_\_ All Medical Records (this includes progress notes, histories, test results, consults, billing, radiology, Referrals, insurance records, records sent to us by other healthcare providers)

\_\_\_\_\_ Medical Records from specific date (insert date) \_\_\_\_\_ to (insert date) \_\_\_\_\_.

\_\_\_\_\_ Other- Please explain \_\_\_\_\_

To include the following records in your request please indicate by initialing

\_\_\_\_\_ Alcohol/Drug Treatment

\_\_\_\_\_ Mental Health Information

\_\_\_\_\_ HIV/STD Related Information

This Authorization expires on \_\_\_\_\_.

**\*\*Unless stated above, this authorization will expire 6 months from date of signature\*\***

The purpose of this disclosure is (required please specify) \_\_\_\_\_.

I understand that I have the right to revoke this authorization at any time, but must do so in writing. This does not affect records sent out in reliance on this authorization prior to receiving the revocation of this request.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

If Representative authority on which acting for patient \_\_\_\_\_

Please be aware that the information disclosed pursuant to this authorization is subject to re-disclosure by the recipient and is no longer protected by this organization.

"REQUIRED" fields must be completed for Release of Protected Health Information.

Highgate Medical Group will not condition the provision of treatment on the provision of this authorization.