OB/GYN ASSOCIATES
OF WESTERN NEW YORK

# CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name:________________________________________ DOB_________________ Account______________

1. I hereby request and authorize OB/GYN Associates of WNY to:

□ Release Information **TO**: □ Obtain Information **FROM:**

2. Name of Provider/Facility _______________________________________________________________
Address____________________________________________________________________________
Telephone______________________________________Fax Number_______________________________________

3. The **PURPOSE** of this release is: (check all that apply)
□ Moving □ Insurance Purpose □ Transferring Care □ Second Opinion
□ Personal Review □ Other (please specify) ______________________________________________________

4. The **FOLLOWING** Protected Health Information (PHI) may be released: (please check one)

□ I consent to the release of **all medical records** including records, reports or tests concerning alcoholism and/or drug abuse or treatment information, sexually transmitted disease related and/or psychological or psychiatric treatment. I also understand that the release of information related to the diagnosis or treatment of HIV requires an additional authorization. (This release excludes any records transferred to OB/GYN Associates from previous care providers.)

□ I consent to the release of **all medical records** with the following exceptions: (Specifically describe the information you do not wish to have released) _______________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

□ I consent to the release of **all medical records** relating to the following treatment or condition:
____________________________________________________________________________________________

□ I consent to the release of **all medical records** from ____________________ to ___________________________
Date Date

5. **This authorization will automatically expire within one year from the date of signature, unless otherwise specified.** I understand that I have the right to revoke this authorization in writing at any time, except where information has already been released in response to this authorization. **Expiration:**__________________________

**Notice to Patient:** NYS Publix Health Law Chapter 45, L1991, C165 Section 58 allows us to charge for copies of records. Our policy is to charge a fee of $.75 per page for copying and administrative costs. This fee will not be charged unless the copying cost exceeds $3.00 and will not exceed a total charge of $25.00.

____________________________________________________________ ______________________
Signature of Patient or Legal Guardian Date

____________________________________________________________
Relationship to Patient