OB•GYN ASSOCIATES OF WNY
Proudly Partnering with General Physician PC

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: _____

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_____

3050 Orchard Park Road | West Seneca, NY 14224 | Ph: (716) 675-5222 | Fx: (716) 674-4200
4845 Transit Road | Depew, NY 14043 | Ph: (716) 675-5222 | Fx: (716) 674-4200
210 East Main st. 2nd floor | Springville, NY 14141 | Ph: (716) 675-5222 | Fx: (716) 794-3132
www.ogawny.com