**CHURCHVILLE-CHILI FAMILY MEDICINE**
*4201 Buffalo Road – P.O. Box 505, N. Chili, NY, 14514*
*Tel: (585) 594-5995 - Fax: (585) 594-5425*

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

| Patient's Name: | | Date of Birth : |
|---|---|---|
| Address: | | |
| City: | State: | Zip : |
| Phone : | | |

☐ I authorize Churchville-Chili Family Medicine to **OBTAIN** information from my previous health care provider:

| Name of Provider, Facility or other person |
|---|
| Address |
| City, State, Zip |
| Phone/Fax # (include area code) |

☐ I authorize Churchville-Chili Family Medicine to **RELEASE** my information to my new health care provider:

| Name of Provider, Facility or other person |
|---|
| Address |
| City, State, Zip |
| Phone/Fax # (include area code) |

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 a not a healthcare or medical insurance provider covered by privacy regulations, the information in your record requested above could be disclosed.
- Request 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) : ______________________________________________