ORCHARD PARK
FAMILY PRACTICE P.C.
3680 EGGERT ROAD • ORCHARD PARK, NEW YORK 14127
(716) 662-5357 • FAX 662-2774

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please allow 10-14 business days for processing. There is a fee of .75 cents per page for copies of medical records.
The medical records cannot be released until this form is completed and signed by the patient or legal guardian.
You must complete this form thoroughly.

PLEASE PRINT

Step I: Patient Name_____ Date of Birth_____

Address_____
Street City State Zip Code

Step II: I hereby authorize Orchard Park Family Practice _____ to release **OR** ____ obtain my health information **FROM**:

Name of Physician/Medical Facility_____

Address _____
Street City State Zip Code Phone # Fax #

Step III: Information to be released:

____ Medical Record from (date) _____ to (date) _____

____ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, referrals, consults, billing records, insurance records, and records sent by other health care providers.

____OTHER: _____

PLEASE INITIAL BELOW TO INCLUDE THE FOLLOWING:

_____ ALCOHOL/DRUG TREATMENT

_____ MENTAL HEALTH INFORMATION (EXCLUDING psychotherapy notes)

_____ HIV- RELATED INFORMATION (must be accompanied by NYS DOH-2557)

_____ GENETIC TESTING

Step IV: Purpose for disclosure is at the request of the individual based on the following: (***This section must be completed before records will be released)***

____Continuity of Care Reason: _____

____Transfer of Care

Step V: CONDITIONS OF AUTHORIZATION

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
I understand that signing this form is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations.
A copy of this authorization has been provided.
This authorization is valid for 90 days for the release of information as indicated by date of signature below.

_____ _____
Patient Signature & Date If not the patient, name and authority to sign on their behalf

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Total Pages _____ @ .75/page (+ postage _____) = _____ TOTAL COST or _____ FLAT FEE

Prepayment – Bill MAILED or FAXED on:_____ Records MAILED or FAXED on:_____

Completed by: _____
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