1010 Main Street Suite 300
Buffalo, NY 14202
Tel: (716)896-2470 Medical Records ext. 4016
Fax (716)218-4000

Authorization for Release of Protected Health Information
Provider Request to Treat/See Patient of WNY BloodCare

All requests can be sent to above address or Fax 716-218-4000 Attn: Medical Records

Patient Name: _____
Address: _____
Phone number: _____ Date of Birth: _____

RECORDS REQUESTED TO BE SENT TO:
Provider Name: _____
_____
Address: _____
_____
Phone number: _____Fax number: _____
Email: _____

The following documents (check all that apply) are requested to be sent to the above provider between the following dates of service: From: _____ To: _____

____ Clinic Notes	____ Progress Notes	____ History & Physical	____ Discharge Summary
____ Radiology Reports	____ Lab Reports	____ Pathology Reports	____ Urgent Care
____ Nurses Notes	____ Operative Reports	____ EKG, EEG, EMG	____ Emergency Room
____ Doctor Consults	____ Doctor Consults	____ Physician Orders	

____ Other, please specify:
_____
_____
_____

This authorization shall remain in effect indefinitely unless indicated by the patient, patient's authorized proxy or parent/guardian.

The patient listed above has the right to revoke this authorization in writing, at any time by sending such written notification to Western New York BloodCare, 1010 Main Street, Suite 300, Buffalo, NY 14202 Attn: Medical Records

Patient Name: _____ DOB: _____

Authorization for Release of Protected Health Information
Provider Request to Treat/See Patient of WNY BloodCare

Internal Use Only:

Date Request Received at WNYBC: _____

Date Request Received in Medical Records Dept: _____

Date Medical Request Completed and Sent to Provider: _____

Format Medical Records Sent to Provider (fax, email, mail): _____

Invoice Sent with Medical Records? Y___ N___ Amount: $_____

Medical Records Associate Name Fulfilling Request: _____