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

Authorization for Release of Protected Health Information
Patient Request for Medical Records

I do hereby consent and authorize Western New York BloodCare, Inc to release copies of my medical records. I also understand I may be charged $.75 per piece if printed and mailed. I also attest that I have presented this request in person and submitted valid identification for myself or as a patient representative.

Patient Name: ____
Address: ____
Phone number: ___________________________ Date of Birth: ___________________________________

RECORDS REQUESTED TO BE SENT TO:
Name: (Patient, Attorney, Provider, Facility, Agency) ____
____
Address: ____
____
Phone number: ____________________________Fax number: ____________________________________
Email: ____
Format in which records are to be received: ______ Fax _____ Email _____ USPS

The following documents (check all that apply) are requested to be sent to the above provider/facility 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:
____
____
____

Please place your initials beside the options below to authorize the release of sensitive information pertaining to:
____ Mental Health ____ Drugs or Alcohol ____ Genetic Testing ____ HIV/AIDS/other infectious diseases

Please select the purpose of your request:
____ Continued Patient Care ____ Attorney/Legal ____ Insurance ____ Social Services/Disability
____ Worker's Compensation ____ Personal ____ Other _________________________

Version 12/9/20

Patient Name: ____DOB: ______________________________

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

You have 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

Signature of Patient or Proxy	Patient or Proxy Printed Name	Date
______________________________	____________________________	___________________
Signature of Parent/ Guardian	Parent/ Guardian's Printed Name	Date
______________________________	____________________________	____________________
Witness (if applicable)	Witness Printed Name	Date
______________________________	____________________________	_____________________

For Office Use Only:

Identification verified by: ____

Medical Record Request Received by: ____

Version 12/9/20