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 _____

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: _____