Family Health Medical Services, PLLC

95 E Chautauqua St
Mayville, NY 14757
716-753-7107

42 Dunham Ave
Jamestown, NY 14701
716-665-7007

320 Prather Ave
Jamestown, NY 14701
716-338-0022

Fax: Mayville 716-753-5367 Jamestown 716-664-6131

Name: _____ DOB: _____

SS#: _____ Date: _____

Authorization To Release Health Care Information

I hereby request and authorize the following release of information:

INFORMATION TO BE RELEASED TO:

_____

_____

_____

INFORMATION TO BE RELEASED FROM:

_____

_____

_____

PURPOSE OF DISCLOSURE:

☐ Continuing Care ☐ Legal ☐ Insurance ☐ At Patient Request for Patient Use ☐ Other (explain) _____

GENERAL MEDICAL INFORMATION:

☐ Complete copy (last 2 yrs unless otherwise indicated)**

☐ Mammo Results ☐ Hospital Records ☐ Immunization records

☐ Eye exam ☐ Lab Results ☐ Other_____

☐ Colonoscopy ☐ Pap Results

_____ _____ _____

Date Signature of patient or auth Rep Relationship to patient if not patient

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RELEASE REQUIRING SPECIFIC CONSENT:

My checkmark and signature below authorize the release of health care information relating to testing, diagnosis or treatment for:

☐ HIV results ☐ Alcohol/Drug information

☐ Mental Health information ☐ Sexually Transmitted Diseases

☐ Reproductive Care (minors only)

MINORS: A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 to 18) (2) alcohol and/or drug abuse (age 13 to 18), (3) mental health conditions (age 13 to 18).

_____ _____ _____

Date Signature of patient or auth Rep Relationship to patient if not patient

☐ Check if patient is a minor

EXPIRATION DATE:

This authorization is effective through ____/____/____ unless revoked or terminated.

Potential for Re-disclosure: If the information that is disclosed under this authorization is sent to anyone other than a health plan or health care provider, it may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulations.

Right to terminate or revoke this authorization: You may revoke this authorization by submitting a written request to the attention of the Privacy Officer.

☐**Patient transfer** – complimentary first copy sent to facility transferred to

☐**Patient personal use** – patient billed $.75 per page

Witness Signature: _____