Family Health
MEDICAL SERVICES, PLLC

fhmsmed.com

103 ALLEN ST · JAMESTOWN, NY 14701
PH 716-338-0022 · FAX 716-338-1567

31 SHERMAN ST · SUITE 2200 · JAMESTOWN, NY 14701
PH 716-338-9797 · FAX 716-338-1567

216 E. MAIN ST · WESTFIELD, NY 14787
PH 716-326-3240 · FAX 716-326-3233

Name: DOB:
SS#: Date:

Authorization To Release Health Care Information

I hereby request and authorize the following release of information:
MEDICAL RECORDS TO BE RELEASED TO:
Family Health Medical Services, PLLC
103 Allen Street
Jamestown NY 14701
Phone: (716) 338-0022 Fax: 716-338-1567
Please send records electronically if you use MEDENT or have a MEDENT-friendly EMR system (N2N direct) to:
practice@fhms.medentdirect.com

MEDICAL RECORDS TO BE RELEASED FROM:

PURPOSE OF DISCLOSURE: ☐Continuing Care ☐Legal ☐Insurance
☐At Patient Request for Patient Use ☐ Transferring WC care only
☐Other (explain) _____

GENERAL MEDICAL INFORMATION:
☐ Complete copy (last 2 yrs unless otherwise indicated)**
☐ Mammo Results ☐ Hospital Records ☐ Immunization records
☐ Eye exam ☐ Lab Results ☐ Last 2 years of workman's comp records
☐ Colonoscopy ☐ Pap Results ☐ Other_____
☐ Last progress note, if no records within the last 2 years from the last time patient was in your office.

Date: Signature:
Relationship to patient if not patient:
Auth Rep = Power of Attorney, Parent, Legal Guardian (accompanied with documentation)

HealthElink Verbal Consent:

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 12 to 18) (2) alcohol and/or drug abuse (age 12 to 18), (3) mental health conditions (age 12 to 18).

Date: 12/02/21 Signature:
Relationship to patient if not patient:
☐**Check if patient is a minor Auth Rep=Power of Attorney, Parent, Legal Guardian (accompanied with documentation)**

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: