

**Patient Authorization for Use and Disclosure of Protected
HEALTH INFORMATION TO THE PRACTICE FROM ANOTHER OFFICE**

1) MEMO TO:

Name of Doctor, Practice, Hospital, Clinic or other Health Care Provider

Address City State Zip

2) MEMO From:

Name of Patient information is being Requested For Date of Birth Social Security #

Address City State Zip

My doctor has provided this HIPAA compliant request/authorization form in order to assist me in requesting you to forward copies of my medical record.

By signing this authorization, I request and authorize you to release certain protected health information (PHI) about me to:

**Southgate Medical Group
1026 Union Road
West Seneca, NY 14224
712-0851 Phone, 712-0853 fax**

3) This authorization permits you to use and/or disclose the following individually identifiable health information about me (**specifically describe the information to be released**, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

All recent progress notes, diagnostics and immunization records.

4) The following information will not be released unless specifically requested by initialing the item:

___ Chemical dependency records (records relating to alcohol or substance abuse)

___ Mental health records (including any care for anxiety or depression)

___ HIV related information (signed NYS form 2557 required)

- The information will be used or disclosed for the following purpose: Future medical care.
- This authorization will expire in 90 days. This disclosure can be revoked at your request.
- When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that your office acted in reliance upon this authorization. My written revocation must be submitted to your Privacy Officer at the address listed above.

5) Signed by: _____

Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

Date

Print Name of Patient or Legal Guardian

Date of Birth