ORCHARD PARK
FAMILY PRACTICE P.C.

3670 SOUTH BENZING ROAD • ORCHARD PARK, NEW YORK 14127
(716) 662-5357 • FAX (716) 662-2774

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please allow 10-14 business days for processing. There is a fee of .75 cents per page for copies of medical records.
The medical records cannot be released until this form is completed and signed by the patient or legal guardian.
You must complete this form thoroughly.

PLEASE PRINT

Step I: Patient Name____ Date of Birth______________

Address____
Street City State Zip Code

Step II: I hereby authorize Orchard Park Family Practice _____ to release **OR** ____ obtain my health information **FROM**:

Name of Physician/Medical Facility____

Address ____
Street City State Zip Code Phone # Fax #

Step III: Please send the following records:

- Immunizations
- Medication List
- Growth Chart
- Problem List/Diagnosis List
- All Hospital/Urgent Care/ER Records
- Psychiatry/Psychology/Mental Health Records
- Colonoscopy
- Mammograms and Pap Smears (last 2 yrs)
- Lab Results (last 2 yrs)
- Progress Notes (last 2 yrs)
- All Consults (last 2 yrs)
- All Imaging (last 2 yrs)

PLEASE INITIAL BELOW TO INCLUDE THE FOLLOWING:

_____ ALCOHOL/DRUG TREATMENT

_____ HIV- RELATED INFORMATION
(must be accompanied by NYS DOH-2557)

_____ MENTAL HEALTH INFORMATION
(EXCLUDING psychotherapy notes)

_____ GENETIC TESTING

Step IV: Purpose for disclosure is at the request of the individual based on the following:(*This section must be completed before records will be released)*

____Continuity of Care Reason: ____

____Transfer of Care

Step V: CONDITIONS OF AUTHORIZATION
I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
I understand that signing this form is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations.
A copy of this authorization has been provided.
This authorization is valid for 90 days for the release of information as indicated by date of signature below.

______________________________________ ____
Patient Signature & Date If not the patient, name and authority to sign on their behalf

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Total Pages _________ @ .75/page (+ postage ________) = __________ TOTAL COST or _________ FLAT FEE

Prepayment – Bill MAILED or FAXED on:_________ Records MAILED or FAXED on:_________

Completed by: ____________
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