Patient Authorization For Use and Disclosure of Protected Health Information To The Practice From Another Office

MEMO TO:

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

_____
Address City State Zip

MEMO FROM:

_____
Name of Patient Date of Birth

Dear Provider Office Or Medical Facility:

My doctor has provided this HIPAA compliant request authorization form in order to assist me in requesting you to forward copies of my medical records.
By signing this authorization, I request and authorize you to use and/or disclose certain protected health information about me to: O'Connor Medical Group
3075 Southwestern Blvd Suite 100
Orchard Park, NY 14127
Fax: 716-712-0615

This authorization permits you to use and/or disclose the following individually identifiable health information about me including all progress notes, diagnostics and immunization records.

Also send the sensitive information checked below:

__Chemical Dependency Records
__Mental Health Records
__ HIV related information

The information will be used or disclosed for future medical care.
This authorization will expire in 90 days.

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.
Signed By:_____ Date_____
Relationship to Patient:_____