RELEASE OF RECORDS TO NEIGHBORHOOD HEALTH CENTER OF WNY

FAX RECORDS TO MEDICAL RECORDS AT 833-464-5151 OR MAIL TO 300 NIAGARA ST, BUFFALO, NY 14201
The Medical Records Department can be reached at 716-242-8600 – Select the option for Medical Records

BLASDELL	BRIDGEVIEW	MATTINA	NORTHWEST	RIVERWAY	SOUTHTOWNS
4233 LAKE AVE	1050 NIAGARA ST	300 NIAGARA ST	155 LAWN AVE	1569 NIAGARA ST	151 ELMVIEW AVE.
Blasdell, NY 14219	Buffalo, NY 14213	Buffalo, NY 14201	Buffalo, NY 14207	Buffalo, NY 14213	Hamburg, NY 14075

Authorization for the Use and Disclosure of Protected Health Information to Neighborhood Health Center

Date: _____ **Patient ID: _____**

Patient Name: _____ **DOB: _____**

Please place authorizing INITIALS on the line next to option A or B below:

A. _____I authorize release of all records except HIV, drug and alcohol treatment.

OR

B. _____ I authorize release of all records including: (Place check marks next to the additional categories that are being authorized for release)

_____ Any notes regarding Behavioral Health consultations and treatment
_____ Any notes regarding Drug and /or Alcohol treatment
_____ Any notes or testing regarding HIV status and related treatment
_____ Any notes from the period _____to _____

The information disclosed in this authorization may be disclosed again by Recipient and if so, may no longer be protected by Provider's privacy practices or federal privacy regulations. However, in the event that these medical records include documentation of alcohol and/or drug abuse, the following statement applies:
THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42CRF PART 2) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS.

For the purpose of: ◯ **TRANSFER to Neighborhood Health Center** ◯ **CONTINUITY OF CARE** ◯ **LEGAL PURPOSES**

Department:

◯ ALL DEPARTMENTS ◯ Internal Medicine ◯ Pediatrics ◯ OBGYN ◯ Behavioral Health ◯ Podiatry ◯ Dental

I authorize my Medical Records to be:

Released from: _____

Address: _____

City _____ State _____ ZIP _____

Phone #_____ Fax #_____

Released to: NEIGHBORHOOD HEALTH CENTER OF WNY

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of our commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purpose described. This form provides that authorization. I understand that I may revoke this authorization at any time or up to one year from the date below.

Patient Signature_____ Date: _____

Witness Name _____ Date: _____