



CHURCHVILLE-CHILI FAMILY MEDICINE
 4201 Buffalo Road – P.O. Box 505, N. Chili, NY, 14514
 Tel: (585) 594-5995 - Fax: (585) 594-5425

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name:		Date of Birth :	
Address:			
City:	State:	Zip :	
Phone :			

I authorize Churchville-Chili Family Medicine to **OBTAIN** information from my previous health care provider:

Name of Provider, Facility or other person
Address
City, State, Zip
Phone/Fax # (include area code)

I authorize Churchville-Chili Family Medicine to **RELEASE** my information to my new health care provider:

Name of Provider, Facility or other person
Address
City, State, Zip
Phone/Fax # (include area code)

PURPOSE FOR THIS REQUEST : Changing Physicians Insurance Coverage Personal Other

TYPE OF RECORDS REQUESTED :

- Treatment summary (includes history/physical, laboratory tests & reports, pathology)
- Entire copy of patient record (NOTICE: this would include ALL sensitive information in your chart such as any HIV related information, mental health related care, substance abuse diagnosis and treatment, etc.)
- All medical records related to a specific illness or injury : _____

Specific timeframe : Dates from : _____ to _____

AUTHORIZATION VALID FOR :

- This request only One year from the date of this authorization (this authorization applies to the records of the treatment received on or prior to the date of this authorization.)

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- There may be a charge for records requested from Churchville-Chili Family Medicine.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information in your record requested above could be disclosed.
- Request for complete records will include any sensitive information contained therein, such as HIV-related information, substance abuse diagnosis and treatment, mental health related care, etc.

Signature of Patient or Representative: _____ Date : _____

Relationship to patient (if requester is not the patient) : _____