



Urban Family Practice
564 Niagara Street Buffalo, New York 14201
Ph. 1-716-882-0366 Fax 1- 716-884-8096

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME: [Last] [First] [MI] ACCT #

PATIENT'S DATE OF BIRTH: SOCIAL SECURITY #:

PHONE # Fax # E Mail

PATIENT'S ADDRESS:

CITY: ST: ZIP:

PLEASE CHECK APPROPRIATE BOX
I hereby authorize UFP to send / release photocopies of medical records concerning the above named patient to NAMED RECEIVER LISTED BELOW.
I hereby authorize THE PROVIDER LISTED BELOW to send / release photocopies of medical records concerning the above named patient to UFP.

(NAME OF COMPANY / PHYSICIAN / AUTHORIZED PERSON / TO RECEIVE / RELEASE RECORDS)

NAME:

ADDRESS:

CITY: ST: ZIP:

PHONE # Fax # E Mail

FOR PURPOSES OF:

- FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL:
1. CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.)
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.
5. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-2801)

MEDICAL RECORDS OF THE LAST TWO YEARS (and/or)
THE FOLLOWING DESCRIBED RECORDS (specify types and dates)

This consent will expire (90) days after the signed date below. I may revoke this authorization at any time providing I notify the above listed doctors in writing to that effect. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentiality.

I HEREBY RELEASE URBAN FAMILY PRACTICE FROM LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.

Signature of Patient

Date Signed

Parent/Legally Authorized Representative

Relationship to Patient

Reason patient was unable to sign release:

PATIENTS 18 YEARS AND OLDER MUST SIGN OWN RELEASE