

FINGER LAKES WOMEN'S HEALTH, LLC

90 OFFICE PARK WAY
PITTSFORD, NEW YORK 14534
585-586-3640

4 COULTER ROAD
CLIFTON SPRINGS, NEW YORK 14432
315-462-5499

MEDICAL INFORMATION FAX: (585) 381-6773

USE FOR BOTH OFFICES

AUTHORIZATION FOR **OBTAIN OR RELEASE** OF MEDICAL INFORMATION (PLEASE CIRCLE ONE)

Patient Name _____	Date of Birth _____
Address: _____	
City/State/Zip Code _____	
Patient Phone#:() _____	Alternate#:() _____
Social Security #: _____	
Date of Request: _____	Date needed: _____

I authorize FLWH, LLC to release/obtain information to/from:

Name of Provider/Facility _____

Address _____ City/State/Zip Code _____

Phone #:() _____ Fax #:() _____

Please send: (check one) All records Ultrasounds/Radiology Labs
 Surgical Reports Office Notes/Correspondence Other: _____

Will you still be making appointments at our office? (Please check one)

YES, I wish to continue being a patient of Finger Lakes Women's Health

NO, I do not wish to continue being a patient of Finger Lakes Women's Health

Please give reason for leaving practice: _____

Authorization Valid For: (check one)

- This request only
- One year from the date of this authorization OR _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.
- This request for medical records of any future treatment of the type described above until _____ (insert date).

I understand that:

- My right to healthcare treatment is not conditioned on this authorization
- 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 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 regulation, the information stated above could be redisclosed
- Release of HIV-related information, mental health related care or substance abuse diagnosis and treatment information requires additional authorization
- **There may be a charge for the requested records.**

Patient Signature

Date

Parent or Legal Guardian

Date

Witness