Finger Lakes Women's Health, PLLC

OBSTETRICS AND GYNECOLOGY

90 Office Park Way
Pittsford, New York 14534
585-586-3640 Fax: 585-586-3796

4 Coulter Road
Clifton Springs, New York 14432
315-462-5499 Fax: 315-462-5490

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, PLLC 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