BUFFALO
OB · GYN

RECORD RELEASE FORM

☐ SCAN
☐ SEND

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Patient Name: _____ Date of Birth: ____/____/____

Address: _____

City, State, Zip: _____ Phone: _____

RECORDS TO BE RELEASED FROM: _____

(Name and address of facility/person receiving records)

CHOOSE ONE

☐ Please release my HIV-related medical records
☐ Do not release my HIV-related medical records

CHOOSE ONE

☐ Recommended: Three most recent pap smears, most recent bone density, most recent mammogram. Pathology and operative reports.
☐ All records
☐ Records for services provided on the following dates: _____
☐ Other: _____

THIS AUTHORIZATION IS VALID UNTIL _____/_____/_____

(UNLESS OTHERWISE STATED, AUTHORIZATION EXPIRES SIX MONTHS FROM DATE OF SIGNATURE)

FAX RECORDS TO: BUFFALO OB • GYN
716.633.4576

OR MAIL TO: 4575 MAIN STREET
AMHERST, NY 14226

This form authorizes release of medical information including HIV-related information. Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or (212) 480-2522 or the New York City Commission on Human Rights at (212) 306-7500. These agencies are responsible for protecting your rights. My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted to release medical and/or HIV-related information of the person named to the organizations/persons listed.

_____

Patient Name (Please Print) Date of Birth

_____

Signature of Patient (or Legal Guardian) Today's Date