

BUFFALO MEDICAL GROUP, P.C.
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH
INFORMATION (IMAGING SERVICES ONLY)

I, _____
Name (REQUIRED)

Date of Birth: _____
(REQUIRED)

Address (REQUIRED)

Daytime Phone: _____

(Social Security Number)

To Be Completed by BMG Personnel Only: Medical Record Number: _____ Date Sent: _____ Sender (Please Print): _____ Signature of Sender: _____
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Authorize Release of my protected health information (PHI) FROM:
Name: _____ TO: Buffalo Medical Group Imaging Department
Address: _____ 295 Essjay Road

Williamsville, NY 14221

This authorization expires: _____ (Unless otherwise stated,
authorization expires six (6) months from date of authorized signature)

I understand that I have the right to revoke this authorization at any time but that I must do so in writing. This does not affect records sent out in reliance on this authorization prior to receiving the revocation request.

- I want the following information to be disclosed: (REQUIRED – Please check all that apply):
- Mammography Films and Reports
 - Ultrasound CD and Reports
 - MRI CD and Reports
 - CT CD and Reports
 - X-Ray Films and Reports
 - All Available previous films and reports

The purpose of this disclosure is for comparison purposes.

Please be aware that information disclosed pursuant to this authorization is subject to re-disclosure by the recipient and is no longer protected by this organization.

Signature of Patient or Representative (REQUIRED)

If representative, authority on which acting for the patient

Date: _____ **PATIENT TO RECEIVE COPY OF THIS FORM**
(REQUIRED)

REQUIRED fields must be completed for Release of Protected Health Information
Buffalo Medical Group, P.C. will not condition the provision of treatment on the provision of this authorization.