**BUFFALO MEDICAL GROUP, P.C.**
**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

I, ________________________________
Name (REQUIRED)

________________________________
Address (REQUIRED)

________________________________

________________________________
(Social Security Number)

Date of Birth:
______________________ (REQUIRED)

Daytime Phone:
____________________

To Be Completed by BMG Personnel Only:
Medical Record Number: _______________
Date Sent: ________________________
Sender (Please Print): ________________
Signature of Sender: _________________

Authorize Release of my protected health information (PHI) FROM:
Name: ________________________
Address: ______________________
______________________________

TO: Name: ________________________
Address: ______________________
______________________________

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 specify):
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

The purpose of this disclosure is: (REQUIRED – Please specify):
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

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.