

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

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: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

TO:

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.