Processed By/Date:_____
MR#:_____

Lifetime Health medical group

Health Information Management Department

Please complete and sign form and return by Mail to:

LHMG Medical Records
205 Park Club Lane
Buffalo, NY 14221

I hereby request and authorize Lifetime Health Medical Group to Release Medical Information*:

Patient Name: _____ DOB: _____

Under 18 years of age? ____Yes ____No

If the patient is a minor and the medical records contain *Ob/Gyn*, *abortion* or *pregnancy* related documentation, the minor's signature is required.

Patient Home Address: _____

Phone #: _____

SEND MY MEDICAL RECORDS TO: _____

_____

_____

What information should be released? _____
(e.g., specify by date, department or problem)

***You will receive the most recent two years of your medical record in an electronic format. If you choose to receive an electronic copy of your full record or records within a specific date range, please make note of that in the line above. Under HIPAA privacy regulations, you have the right to request a complete copy of your medical information. If you would prefer your medical records in paper format, we will copy the most recent two years as a courtesy, free of charge. Information prior to the two years provided is available at a charge of 75 cents per page (for copying costs) as permitted by New York State law. On average, the minimum number of pages included in a medical record is 200 and the cost could be significant. If you are interested in requesting your complete record in paper format, please call the number listed above for an estimate of cost.**

Do your medical records contain information related to *HIV/AIDS* counseling or testing, *Behavioral Health* notes or other information regarding the treatment of *depression/anxiety*, or counseling and/or treatment of *alcohol/drug abuse*?

____No, my medical records do not contain the identified sensitive information.

____Yes (The ***patient*** must complete the appropriate *Authorization for Release of Sensitive Information* on the following page.)

Purpose for release of medical information:

____ Transfer of Medical Care Effective Date: _____

Reason for Transfer: _____

____ Referral to Specialty Provider ____ Immunization Records

____ Disability ____ Workers Compensation/No Fault

____ Other: _____

I understand that I have the right to revoke this authorization, in writing, at any time. (Requests to revoke an authorization must be directed to the attention of the Lifetime Health Medical Group, Health Information Management Department.) I understand that the two exceptions to the right to revoke are: (1) where Lifetime Health Medical Group has acted in reliance upon the authorization; (2) if the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the privacy regulations. I also understand that this authorization is effective for release of information prior to the date it has been signed and unless otherwise indicated, this authorization will expire in 90 days. I further understand that this authorization is voluntary and Lifetime Health Medical Group will not refuse treatment based on my refusal to sign. I hereby authorize release of the requested medical records.

Signature: _____ Date: _____

Relationship to Patient (if other than Self): _____

Witness: _____

GP-2227 12.17

Authorization for Release of Sensitive Information by Lifetime Health Medical Group

I hereby give permission to Lifetime Health Medical Group to release:

_____,
(Describe Sensitive Information to be released)

for _____,
(Purpose of the disclosure)

from the medical record of:

Patient Name: _____ DOB: _____

To: _____
(Recipient of Sensitive Information)

(Recipient's address)_____

_____

Signature: _____ Date: _____

Relationship to Patient: _____

Witness: _____

***This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate in 90 days.