Authorization for Release of Protected Health Information

BUFFALO NUTRITION & DIETETICS, PLLC

FAX: (716) 625-1236 / Phone: (716) 704-0684

Patient Name (REQUIRED):

I, _____ , Date of Birth: _____

Address (REQUIRED): Daytime Phone: _____

_____

_____

_____

Authorize release of my protected health information (PHI) **both TO and FROM Buffalo Nutrition & Dietetics, PLLC** and the following Physicians and/or Health Care Providers:

Doctor/Provider #1:

Name: _____

Address: _____

_____

Phone: _____

FAX: _____

Doctor/Provider #2:

Name: _____

Address: _____

_____

Phone: _____

FAX: _____

I would like the following information to be disclosed to Buffalo Nutrition & Dietetics, PLLC **WITHIN 5 business** days of my request:

_**X**_ All complete and recent blood work
_**X**_ Most recent MD annual physical and progress note (s)
_**X**_ All previous dietitian notes on file
_**X**_ Nutritionally pertinent Films and Reports

Prefer: Fax Copy _**X**_ Paper Mail Copy ___

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 additional information to be disclosed: In addition to the items checked above, any additional records specifically requested by receiving provider's office.

The purpose of this disclosure is: Continuity and collaboration of care between medical providers.

Please be aware that information disclosed from Buffalo Nutrition & Dietetics, PLLC pursuant to this authorization is subject to re-disclosure by the recipient and is no longer protected by this practice.

_____ Date: _____ (REQUIRED)

Signature of Patient or Representative (REQUIRED)

If Representative, authority on which acting for the patient: _____

PATIENT SHOULD KEEP COPY OF THIS FORM. "REQUIRED" fields must be completed for Release of Protected Health Information.

Revised: 08/10/2018