ADULT MEDICAL SERVICES PC
6645 Main St. Suite A, Williamsville, NY 14221
(716) 276-8726 (Office)
(716) 276-8730 (Fax)

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient _____
Last Name First Name Middle Initial

Address_____

Date of Birth _____

ADULT MEDICAL SERVICE is authorized to furnish to/receive from (circle desired choice):
Recipient/Discloser: _____

For the Purpose of: _____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

☐ I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records r copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMSATION which may include information concerning mu treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapists, psychologists, if any.

☐ I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

_____

_____

I release Adult Medical Services, Inc, and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Adult Medical Services, PC, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on __/__/__(Optional). If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.

_____ _____
Patient Signature (Parent's Representative if minor) **Date**

_____ _____
Witness Signature **Date**

So that we may improve our patient care, please let us know the reason you are requesting this record release (check all that apply):

☐ **Not satisfied with Provider (which provider?)_____**

☐ **Not satisfied with Staff (which staff member?)_____**

☐ **Moving out of the area_____**

☐ **Other (please describe)_____**