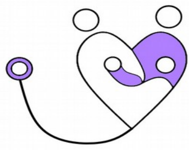

Cheryl Newman M.D.
Family Medicine

Authorization to Release Medical Information

2550 Baird Road
Penfield, NY 14526
585-395-1111
585-395-1116 (fax)
www.cherylnewmanmd.com

Patient Name: ______________________ **Patient Date of Birth:** ______________

Patient Address: ______________________ **Patient Phone Number:** ______________

City/State/Zip Code: ______________________

This authorization allows Cheryl Newman M.D. to (*check one*):

☐ **<u>Send</u>** copies of your record to (or discuss your information with) the provider/person/facility below.

OR

☐ **<u>Receive</u>** copies of your record from (or discuss your information with) the provider/person/facility below.

______________________ ______________________
Name of Provider/Person/Facility **Address**

______________________ ______________ ______________
City/State/Zip Code **Phone #** **Fax #**

Purpose for this Request: ☐ Healthcare ☐ Insurance Coverage ☐ Personal
☐ Other ______________________

Type of Records/Information Requested (*check all that apply*):

☐ **Inpatient:** **Dates** ______________________

☐ Treatment summary (*includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology*).

☐ Specific information or reports (*please describe*): ______________________

☐ **Outpatient/Office Visits:** **Date(s)** ______________ **and/or Specific Illness/Injury** ______________

☐ **Other (*please describe*):** ______________________

I understand that:

- I may cancel this authorization at any time by submitting a **<u>written</u>** request to the address provided on front of this form (at the top). I understand that the cancellation will not apply to information that has already been released in response to this authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- I authorize release of HIV-related information, mental health-related care or substance abuse diagnosis and treatment information.
- **There may be a charge for the requested records ($.075/page for paper copies).**

Authorization valid for one year from the date of this authorization **OR** ______________________ (insert date).

Signature of Patient: ______________________ **Date:** ______________

Relationship to Patient (*if requestor is not patient*): ______________________