PAIN MANAGEMENT ASSOCIATES OF WNY

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AUTHORIZATION FOR HEALTH INFORMATION RELEASE

As requires by the Health Information Portability and Accountability Act of 1996 (HIPPA) you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant or explain the reason why the request will not be granted. Your right to access does not extend to information compiled in reasonable participation of, or for use in, a civil, criminal, or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider.

I hereby request access to health information for:

NAME: _____ DOB: _____

ADDRESS: _____

RELEASE INFORMATION TO:

☐ self ☐ other: _____

ACCESS REQUESTED:
☐ all records
☐ portion of records concerning: _____
(specifically condition, accident, date of treatment, or other portion of records to be released)

CHARGES: Per NYS Medical Records Charge is equivalent to $0.75 per sheet.

SIGN: _____ DATE: _____

PRINT NAME: _____ PHONE#: _____

If not signed by the patient, please indicate:
RELATIONSHIP:
☐ parent or guardian of minor patient
☐ guardian of conservator of an incompetent patient
☐ beneficiary or personal representative of deceased patient
☐ other (specify) _____

~ this authorization will automatically expire one year from today's date ~