

NEIGHBORHOOD HEALTH CENTER
Check Location

NORTHWEST
155 LAWN AVE
Buffalo, NY 14207
Phone: 716-875-2904
Fax: 716-875-5346

MATTINA
300 NIAGARA ST
Buffalo, NY 14201
Phone: 716-242-8600
Fax: 716-332-0832

SOUTHTOWNS
151 ELMVIEW AVE.
Hamburg, NY 14075
Phone 716-648-4345
Fax 716-648-4385

Blasdell
4233 LAKE AVE
Blasdell, NY 14219
Phone 332-3070
Fax 332-3075

Authorization for the Use and Disclosure of Protected Health Information

Date: _____ **Patient ID:** _____

Patient Name: _____ **DOB:** _____

Please **CHECK** and **INITIAL** one:

_____ I authorize release of all records except HIV, drug and alcohol treatment unless checked below.

OR

_____ I authorize release of all records including: **(Check additional information requested below)**

- _____ Any notes regarding Behavioral Health consultations and treatment
- _____ Any notes regarding Drug and /or Alcohol treatment
- _____ Any notes regarding HIV related treatment
- _____ Any notes from the period _____ to _____
- _____ Any blood test results for Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV)

The information disclosed in this authorization may be disclosed again by Recipient and if so, may no longer be protected by Provider's privacy practices or federal privacy regulations. However, in the event that these medical records include documentation of alcohol and/or drug abuse, the following statement applies:

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42CRF PART 2) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS.

For the purpose of: TRANSFER CONTINUITY OF CARE LEGAL PURPOSES SELF

Department:

- ALL DEPARTMENTS Internal Medicine Pediatrics OBGYN Behavioral Health Podiatry Dental Endocrinology

Released by: NEIGHBORHOOD HEALTH CARE CENTER (Formerly Northwest Buffalo Community Health Care Center)

Released to: _____

Address: _____

City _____ **State** _____ **ZIP** _____

Phone # _____ **Fax #** _____

Your records are available to be released to you electronically via Healthport. If you wish your records to be sent to you via Healthport, please provide your email address below. *Please note that your email must be valid in order to receive your records. Healthport may also charge you 75¢ per page for this service.*

Email address _____

WE understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of our commitment, we must obtain your written authorization before we may use or disclose your protected health information for the purpose described. This form provides that authorization. This form provides that authorization. I understand that I may revoke this authorization at any time or one year from the date below

Patient Signature _____ **Date:** _____