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 CONFIDNTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42CRF PART 2) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOUSRE 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 To: **NEIGHBORHOOD HEALTH CARE CENTER (Formerly Northwest Buffalo Community Health Care Center)**

Released from: ____

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:** ____________________