Associated Physicians of Western New York, P.C.

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form provides authorization to our practice to use or disclose certain of your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

Patient Name:_____ DOB: _____

Address: _____

- Who will be disclosing the information? Name of person or entity, or category of persons/entities authorized to make the requested use of disclosure:

_____

_____

- Who will be receiving or using this information? Name of person or entity, or category of persons/entities, to whom the use of disclosure may be made:

_____

_____

- What information will be used or disclosed? The following is a specific description of the information to be used or disclosed, but not limited to, the date(s) of service provided, level of detail to be released, origin of information, etc.:

_____

_____

- What is the purpose of the use and disclosure? This information is being used or disclosed for the specific purpose(s) below. If you have requested use or disclosure of the information but do not, or elect not to, provide a statement of purpose, we will state "at the request of the individual".

_____

_____

This authorization will expire on (Date): _____

Signatures: I have read and understand the terms of this authorization, and I understand that I may revoke this authorization in writing to the appropriate person.

_____ _____

Patient – Print name above Date

_____

Patient Signature

_____ _____

Witness Signature Date