5823 Widewaters Parkway

East Syracuse, New York 13057

Phone: (315) 500-SKIN (7546)

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Medical Records Release Form

Patient Name:Date of Birth: 

Person Requesting Records and Relationship:

Home Phone: Daytime Phone:

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

|  |
| --- |
| HIV/AIDS: I DO NOT consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. Initial:Date: |

Limitations on the information you may release, subject to this Release Form are as follows:

Release my protected health information to the following person(s)/entity:

Name:

Street:

City: State:  Zip:

 Do NOTgive permission for these records to be faxed to the above entity.

The reasons or purposes for this release of information are as follows:

Patient Signature [or parent, guardian or legal representative] Date