DENT
3980 Sheridan Drive, Amherst, NY 14226
200 Sterling Drive, Orchard Park, NY 14127
35 Batavia City Center, Batavia, NY 14020
Phone: 716.250.2000 Fax: 716.250.2045

There is a fee of $0.75 per page plus postage for records not being sent directly to another physician or medical facility. Requests are processed by a copy service and are mailed within 15 business days from receipt of this request. No records are to be picked up at Dent.

Authorization to Release Medical Records

Patient Name: _____ **Date of Birth:** _____
(Please Print)

Patient Address: _____
(Street) *(City)* *(State)* *(Zip)* *(Telephone Number)*

Release/Send Information to:

I hereby authorize: ☐ DENT Neurologic Institute **OR** ☐ Other Facility (*Please list facility information below*)

To release information contained in my medical record to:
☐ DENT Neurologic Institute **OR** ☐ Other Facility (*Please list facility information below*)

_____
(Name of Person or Other Facility-Please Print)

_____
(Street)

_____
(City) *(State)* *(Zip)* *(Telephone Number)* *(Fax Number)*

Purpose of release: ☐ Continuation of Care ☐ Personal ☐ Legal ☐ Insurance ☐ Transferring of care

If leaving DENT Neurologic Institute please check reason(s):
☐ Dissatisfied With Care/Service Received (please explain on reverse) [*DWC*] ☐ Appointment Wait Time [*AWT*]
☐ My Provider Left [*MPL*] ☐ Moved/planning to move [*MOV*] ☐ Location/wanted some place closer [*LOC*]
☐ Insurance change [*INS*] ☐ Other: _____ [*OTH*]

Information to be released (*Check all that apply*):
☐ Office notes _____ to _____ Specific Providers: _____
(Please specify date range) (Specific providers must be named for release of sensitive information – see below)
☐ Diagnostic/Imaging Reports _____ to _____
(Please specify date range)
☐ Lab Results _____ to _____
(Please specify date range)
☐ Abstract (Last 2 years of patient care including office notes, labs, and diagnostic/imaging reports)
☐ Billing Records _____ to _____
(Please specify date range)
☐ Other _____

Release of sensitive information: The following categories of information may be included in your medical record but ***WILL NOT*** be released without ***INTITIALING*** the appropriate section:

_____ Abortion _____ Alcohol/Drug Treatment _____ Domestic Violence _____ Genetic Testing
_____ HIV-Related Information _____ Mental Health Information _____ Rape/Sexual Assault _____ Research
_____ Sexually Transmitted Diseases _____ Other: _____

I understand/acknowledge that:
- All items on this form have been completed and my questions about this form have been answered.
- I have been provided a copy of the form (at my request).
- This authorization will automatically expire in one year from date signed or the following date of expiration: ___/___/_____

_____ _____
Signature of patient or representative authorized by law Date

_____ _____
Print Name of patient or representative authorized by law Relationship to Patient