IN TOUCH ADULT HEALTH NPS, P.C.

Authorization to Release Medical Records to:

In Touch Adult Health NPs, P.C.
Phone (716) 458-1100
Fax (716) 458-1101

I hereby authorize: **In Touch Adult Health NP PC**, located at:1408 Sweet Home Rd. Amherst NY Suite 12

***To <u>REQUEST</u> my Medical Records and/or MRI Imaging <u>Records from</u>*: (List Dr.'s below)**

Patient's Name: _____Phone number: _____
Address: _____
City, State, Zip Code_____
Date of birth: _____ Date of request: _____

Medical Records are to be **sent to**: **In Touch Adult Health NP PC**, 1408 Sweet Home Rd. Amherst NY Suite 12, 14228.

Fax Number records to be faxed to***: 716-458-1101***

Please check and complete all that apply.
____ Medical Records for Date(s) of: _____
____MRI Imaging and Area for Date(s) of: _____
____Other, please be specific: _____

Name of Doctor: _____
Phone: _____
Fax: _____
Address: _____

Name of Doctor: _____
Phone: _____
Fax: _____
Address:_____

Name of Doctor: _____
Phone: _____
Fax: _____
Address: _____

Name of Doctor: _____
Phone: _____
Fax: _____
Address: _____

I have read this Authorization and I acknowledge being familiar and fully understand its terms and conditions.

_____ _____
Signature of Patient or Personal Representative Date

(Over)

IN TOUCH ADULT HEALTH NPS, P.C.

For authorized person(s) to <u>RELEASE/DISCLOSE)</u> your Medical Records and/or MRI Imaging records (ex: Primary Physician) We will provide information on <u>care given to you</u>, to whomever you wish to know outside of this office

Patient's Name: _____Phone number: _____
Address: _____
City, State, Zip Code_____
Date of birth: _____ Date of request: _____

Medical Records <u>from</u> "In Touch" may be released to (outside entity):

Name of Doctor: _____
Phone: _____
Fax: _____
Address: _____

Name of Doctor:_____
Phone: _____
Fax: _____
Address: _____

Name of Doctor: _____
Phone: _____
Fax: _____
Address: _____

Name of Doctor: _____
Phone: _____
Fax: _____
Address: _____

Health Information to being disclosed for the following purpose: (check all that apply)
____Change in Insurance or Healthcare Provider
____Continuation of Care

Please Note: The attached medical information pertaining to (patient name) _____is confidential and legally privileged. In Touch has provided it to (other provider) _____ as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient or as authorized by law. I hereby release **In Touch Adult Health NPs PC** from any and all liability which may arise as a result of my authorized release of records. I understand that **In Touch Adult Health NPs PC** may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I have read this authorization and acknowledge the terms and conditions.

I understand that this information shall be in effect for 180 days following the date of signature. Further, I may revoke this authorization at any time by giving oral or written notice to In Touch Adult Health NPs, P.C. A photocopy of this authorization shall constitute a valid authorization. I realize once my medical records have been released to In Touch Adult Health NPs, P.C. my revocation cannot be effective to the extent which the healthcare provider has taken the action and with the reliance of this Authorization.

I understand that the health information I am authorizing may disclose additional information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

I understand that In Touch Adult Health NPs, P.C. may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I have read this Authorization and I acknowledge being familiar and fully understand it's terms and conditions.

_____ _____
Signature of Patient or Personal Representative Date