DENT
NEUROLOGIC INSTITUTE
3980 Sheridan Drive, Amherst, NY 14226
200 Sterling Drive, Orchard Park, NY 14127.
40 George Karl Blvd, Buffalo, NY 14221
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. Please allow up to 30 business days for medical records to reach the recipient. 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 ***INITIALING*** 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:

- This authorization will automatically expire in one year from date signed or the **following date of expiration**:____/____/_____
- 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).

_____ _____
Signature of patient or representative authorized by law Date

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_____ _____

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