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

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:________________	_____ Memory Testing	

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

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

If your office is set up to send electronically (via Direct Message), <u>please use this as the preferred option</u>. Our Direct Message name is generalrecords.dentneurologicinstitute@dent.eclinicaldirectplus.com Alternatively, you may fax your records to (716) 250-2045.