DAVID S. CLIFFORD, MD
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West Seneca, NY 14224

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Dear Patient,

We are in receipt of a request for a copy of your medical record.

May I ask that a remittance of **$10.00** be sent upon receipt of this letter for the release of your records. Your records will be released and mailed directly to your forwarding Doctor at the receipt of this payment. According to the U.S. Department of Health & Human Services providers may charge a reasonable price to cover the copying materials and mailing of records.

Should you have any questions, feel free to contact our office. Thank you.

Sincerely,

David S. Clifford, M.D.

David S. Clifford, M.D.

David S. Clifford, M.D., A.B.F.P.
Heather L. Bailey, P.A. – C
Deirdre L. Schwartz, FNP
256 Center Rd.
West Seneca, NY 14224
Phone: (716) 677-4159

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

By signing this authorization, I authorize DR. DAVID CLIFFORD to release certain protected health information (PHI) about me.

Name and address of entity (FUTURE DOCTOR) to receive this information:

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This release permits the above Previous Doctor to disclose the following individually identifiable health information about me from the **PAST TWO YEARS ONLY**. This will include: all office notes, latest labs, test results, consultation letters, immunization record, and any other important information. Information will be used or disclosed for the following purpose: **future medical care**.

Please, DO NOT FAX as it ties up our fax line. Please mail the records as a paper copy or on a CD, or send them electronically through eClinicalWorks P2P.

I understand the implications and hereby authorize the release of the following records relating to:
____Alcohol/Drug Abuse ____HIV/Sexually Transmitted Disease

____Mental Health Concerns (Including any care for anxiety or depression)

I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the practice listed above.

______________________________________ ____________________
Signature of Patient or Legal Guardian Date

____
Print Name Birthdate Address

_____________________________ Relation (If Parent/Guardian or Name other than patient)