David S. Clifford, M.D., A.B.F.P.
256 Center Rd.
West Seneca, NY 14224
Phone: (716) 677-4159
Fax: (716) 677-4470

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 Provider to disclose the following individually identifiable health information about me from my chart. This will include office notes, latest labs, test results and consultation letters. Information will be used or disclosed for the following purpose: **FUTURE MEDICAL RECORDS RELEASE FEE IS $10 FOR CD COPY AND $15 FOR PAPER COPY.**

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

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_ Print Name Birthdate Address

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