Rheumatology Consultants of WNY, P.C.

3615 Seneca Street

West Seneca, NY 14224

Telephone (716)675-7376 Fax (716)675-2191

I, (Name)_____DOB:_____

(Address)_____Phone #:_____

_____SS#_____

Authorize the release of my protected health information **To / From** :

Name:_____

Address:_____

Fax:_____ Telephone:_____

To / From: Rheumatology Consultants of WNY, PC/_____

This authorization expires:_____(unless otherwise stated, authorization expires (6) months from date of authorized signature).

I understand that I have the right to revoke this authorization at any time but that I must do so in writing. This does not affect records previously sent out prior to receiving the revocation request.

I want the following information to be disclosed:

___ Laboratory reports

____ x-ray reports

____ x-ray films/CD

____ Discharge Summaries

____ All Records

The purpose of this disclosure is for continued medical treatment.

X_____ Date:_____

Signature of Patient or Representative