Quaker Medical Associates
Authorization for Disclosure of Health Information

This form authorizes Quaker Medical Associates
3560 North Buffalo Road
Orchard Park, NY 14127

To disclose the following specific information:

☐ Entire medical record. *This includes lab results, medications, test results, and appointment notes from both Quaker Medical and any outside specialists you may have seen.*

☐ Sensitive Information. *This includes testing for STD's, HIV, drug, alcohol, and mental health counseling.*

To (*name of person and/or facility):*______________________________

Address:

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This authorization may be revoked by the undersigned individual at any time by submitting a written notice of revocation to the provider. However, any revocation shall not apply to the extent that the provider has taken in reliance on this authorization.

The information disclosed pursuant to this authorization may be disclosed again by recipient and if so, may no longer be protected by providers or recipients privacy practices or federal privacy regulations.

By signing my name below, I hereby acknowledge that I have read and fully understand this form. I understand that medical treatment, payment, enrollment in a healthcare plan, and eligibility for benefits may not be conditioned on my signing this authorization. I acknowledge that I may refuse to sign this authorization and that I am signing this authorization voluntarily.

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Printed Name of Individual/DOB

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Signature of Individual/Date

____

Signature of Personal Representative/Date
(e.g., Attorney-in-fact, Guardian)

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Description of Authority to act as Personal Representative (*if needed*)