Harmony Health of WNY

3545 Buffalo Rd. #6
Rochester, NY 14624

Phone: 585-684-3556 | Fax: 585-360-1701 | christine@harmonyhealthwny.com | www.harmonyhealthwny.com

Authorization to Release Healthcare Information

Patient's Name:	Date of Birth:
Previous Name:	Social Security #:
I request and authorize the following Medical Provicer to release healthcare information of the patient named above to:	Dr. Mark Sarnov, MD c/o Harmony Health of WNY 3545 Buffalo Rd., #6 Rochester, NY 14624

Previous Physician/Office: _____

Address: _____

Phone: _____ Fax: _____

This request and authorization applies to:

◯ Healthcare information relating to the following treatment, condition, or dates

◯ All healthcare information ◯ Other

[List here]

[Additional information]

DECLARATION

◉ Yes ◯ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

◉ Yes ◯ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed:

THIS AUTHORIZATION EXPIRES ONE HUNDRED AND EIGHTY DAYS AFTER IT IS SIGNED.