Maple Internal Medicine & Pediatrics
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Williamsville, NY 14221
(716) 634-5410

FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my health information to the following person(s):

Name: _____

Relationship to Patient: _____

Telephone Number: _____

Exp. Date: N/A

I understand and agree to the foregoing:

Sign: _____ Date: _____

Print Name of Patient: _____

If you are signing as the patient's guardian (if patient unable to sign for themselves):

Print your name: _____

Describe your authority: _____