**MAPLE INTERNAL MEDICINE & PEDIATRICS**
**1835 MAPLE ROAD**
**WILLIAMSVILLE, NY 14221**
**(716)634-5410**

# RELEASE OF INFORMATION FORM

PATIENT NAME:_______________________________________________
ADDRESS: _______________________________________________
_______________________________________________
DATE OF BIRTH:_______________________________________________

**PLEASE CHECK APPROPRIATE CIRCLE:**

◯ I hereby authorize Maple Internal Medicine & Pediatrics to release photocopies of my medical Records to the provider listed below.

◯ I hereby authorize Maple Internal Medicine & Pediatrics to obtain photocopies of my medical records **FROM** the provider listed below. You may send these records by CCD if you have MEDENT or mail them to our office. (WE DO NOT ACCEPT DISCS/CD'S)

**PROVIDER – Physician's Name & Address**

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

◯ I hereby authorize the office of Maple Internal Medicine & Pediatrics to release photocopies of my records to myself. I understand I am receiving these records without a clinical interpretation and should not attempt to draw conclusions from the records without the assistance of my primary care physician and I am aware that there will be a charge of $.50 per page or a minimum of $5.00 to copy my medical records.

This consent will expire one year after the signed date below. I may revoke this authorization at any time providing I notify Maple Internal Medicine & Pediatrics in writing to that effect. I understand that any release which was made prior to my revocation follows this authorization and shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. I hereby indemnify Maple Internal Medicine & Pediatrics against all legal responsibility of liability that would be caused by the action of releasing my records as authorized above.

_______________________________________________ _______________________
Patient Signature Date

_______________________________________________ _______________________
Patient/Legally Authorized Rep. Relationship to Patient