Dr. Diane M. Sanfilippo
410 Abbott Road
Buffalo, NY 14220
Main: 716.827.4850
Fax: 716.827.4851
www.dmsmd.com

MEDICAL RECORD REQUEST

Name:_______________________________________ **DOB:** _______________________________________
Address: _____________________________________ **Phone:** ______________________________________

I am requesting copies of my medical records from (Previous or Current Dr. or Medical Office)

Name: ____
Address: ____
City: ____
Phone: __________________________________ **Fax#** ________________________________

Please forward copies of my medical records to :

Dr. Diane M. Sanfilippo
410 Abbott Road
Buffalo, NY 14220
Fax: 716-827-4851

Dear Provider Office or Medical Facility:

By signing this HIPAA compliant authorization, I request and authorize you to use and or disclose certain Protected Health Information (PHI) about me to Dr. Diane Sanfilippo with an office at the above address. This authorization permits you to disclose the following individually identifiable health information.

Last two years or most recent exams, notes diagnostic tests, paps, mammograms, any operative reports, any prenatal and postpartum notes, other specifically described info below:

CHOOSE ONE
- ☐ Please release my HIV-related medical records
- ☐ Do not release my HIV-related medical records

CHOOSE ONE
- ☑ Recommended: Three most recent pap smears, most recent bone density, most recent mammogram. Pathology and operative reports.
- ☐ All records
- ☐ Records for services provided on the following dates: ______________________
- ☐ Other:

This authorization will expire on: ____

When my information is used to disclosed, pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy rule. I have the right to revoke this authorization in writing except to the extent that your office acted in reliance upon this authorization. My written revocation must be submitted to the privacy office or custodian of records at the address listed above.

SIGNATURE: ____ **Date:** ____________________________
LEGAL GUARDIAN (if minor) ____________________________________ **Relationship:** ________________________
Witnessed by: (print): ____ **Signature:** __________________________