**CONSENT FOR RELEASE OF INFORMATION** New York Physical Medicine Center

1295 Portland Avenue, Ste 9

Date: Rochester, NY 14621

I, give permission to release and/or obtain Medical information.

Print Last Name First Middle

Other specific information to be obtained (please initial appropriate authorization)

Psychiatric Drug/Alcohol HIV Records

Regarding D.O.B. SS#

I hereby declare that I am the: [ ] Patient [ ] Parent [ ] Legal Guardian

**Information Released To: Info. Released From: Doctor’s name/contact info.**

Matthew Grier, DO, Brianne Sisca, PA, Greg Maier, DPT

New York Physical Medicine Center, LLC

1295 Portland Avenue, Ste. 9

Rochester, NY 14621

Information to be release shall include:

· Lab Tests · Physical Therapy Information · Treatment Plans

· Medical Information · Discharge Summaries · Medication Info

· Evaluations · Progress Notes · Diagnostic Testing

I may cancel this authorization to the extent followed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that cancelling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

I authorize the periodic (ongoing) release of the above information. This consent expires when services are discontinued.

Initial

I, the undersigned, have read the above and authorize staff at the facility named to release/obtain such information as indicated. I understand that this consent may be withdrawn by me, by phone or written notice, at any time except to the extent the action has already been taken. I understand the disclosure of mental health-related clinical records is bound by New York State Mental Hygiene Law and Drug’Alcohol records are bound by federal regulations governing confidentiality, 42CFR Part 2 and the redisclosure of this information to a party other than one designated above is forbidden without additional written authorization on my part.

Patient Signature Date Witness Date

Parent/Legal Guardian Date

[ ] Via Phone [ ] Via Written Consent

Patient has withdrawn consent Date