Saman B. Chubineh, M.D.
www.giwny.com
Phone: 716-240-2296
Fax: 716-462-6000

North Tonawanda
415 Tremont Street
North Tonawanda, NY 14120

Lockport
15 Elizabeth Drive
Lockport, NY 14094

Lewiston
5290 Military Road 10B
Lewiston, NY 14092

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ Date of Birth: _____
Name (REQUIRED)

_____ Daytime Phone: _____

_____
Social Security Number: _____

_____
Address (REQUIRED)

Authorize release of my protected health information (PHI) from the following provider:

FROM:
Name: _____

Address: _____

_____

TO:
Saman B. Chubineh, M.D.
415 Tremont Street
N. Tonawanda, NY 14120
Fax 716-462-6000

I would prefer the following information to be disclosed: (REQUIRED-Please check all that apply):
___ All Medical Records (excluding imaging films)
___ All Medical Records (including imaging films marked below)
___ Imaging films only (as marked below)
___ Ultrasound CD and Reports
___ MRI CD and Reports
___ CT CD and Reports
___ X-Ray Films and Reports
___ All available previous films and reports

This authorization expires: _____ (Unless otherwise stated, authorization expires six (6) months from the date of authorized signature.)
I understand that I have the right to revoke this authorization at any time but that I must do so in writing. This does not affect records sent out in reliance on this authorization prior to receiving the revocation request.
The purpose of this disclosure is: (REQUIRED-Please Specify):_____

Please be aware that information disclosed pursuant to this authorization is subject to re-disclosure by the recipient and is no longer protected by this organization.

_____
Signature of Patient or Representative (REQUIRED)

If Representative, authority on which acting for the patient:

Date: _____ (REQUIRED) **PATIENT SHOULD KEEP COPY OF THIS FORM**