MARY LOUISE LENAHAN, M.D.
6507 TRANSIT ROAD
EAST AMHERST, NY14051
716-689-4377
FAX: 716-689-4843

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

RE:_____ DOB:_____

(Circle One) I am the ***Patient*** or ***Person Responsible*** for the individual named above & authorize release of protected health information to Dr. Mary Louise Lenahan, M.D. at 6507 Transit Road, East Amherst, NY 14051 by mail or by facsimile transmittal.

I am requesting this information to be obtained from _____
(NAME OF PERSON FROM WHOM INFORMATION IS REQUESTED)

Specific information to be released or obtained:

All medical records to include biopsies, laboratory results and any other medical information necessary for treatment.

This authorization expires when services are discontinued or at the date I hereby state:_____
(Expiration Date If Desired)

This information is necessary for the purpose of ongoing medical care and further treatment.

I understand that I have the right to revoke and/or restrict this authorization at any time provided that I submit a request in writing to the agency Privacy Office. Any revocation shall not apply to the extent that Dr. Lenahan has already taken action in reliance on this authorization.

Signature_____ Date_____

Relationship to Patient_____

Witness_____ Date_____