Permission to Release Medical Information

Patient's Name: _____ Date of Birth: _____

- ☐ Medical records related to claim or current exam
- ☐ Diagnostic reports related to claim or current exam
- ☐ Progress Reports
- ☐ Other: _____
- ☐ All medical records on file
- ☐ All diagnostic reports on file
- ☐ Immunization records

I am granting permission for WorkFit Medical, LLC and Rochester Walk In Care Medical Treatment:

- ☐ To **release** the above information **to:**
- ☐ To **obtain** the above information **from:**

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Telephone

- ☐ I understand this consent will remain in effect for the duration of your employment with the above named organization.
- ☐ I understand this consent will remain in effect for duration not to exceed 5 years from the date of signature.

I may withdraw my consent in writing at any time except where a disclosure has already been made in reliance on my prior authorization. I also understand that privacy rules may not protect against re-disclosure of this information. If access is denied pursuant to New York State Public Health Law, I will be so notified and provided information on the appeal process.

_____ _____
Signature Date

IF PATIENT IS A MINOR OR IS OTHERWISE NOT CAPABLE OF INFORMED CONSENT:

I, _____ Being the ☐ PARENT ☐ LEGAL GUARDIAN ☐ OTHER
Of the above named individual, have reviewed the above information and consent to the release of information as above.

_____ _____
Signature Date

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax

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Batavia, NY 14020
(585) 343-0334 Phone
(585) 343-0336 Fax

1971 Western Avenue, Suite 4
Albany, NY 12203
(518) 452-2597 Phone
(518) 452-2526 Fax