

Amherst Medical Associates, LLP
6000 N. Bailey, Amherst New York 14226

***Patient Authorization for Use and Disclosure
of Protected Health Information from the Practice***

By signing this authorization, I authorize Amherst Medical Associates, LLP (the practice) to use and/or disclose certain protected health information (PHI) about me to:

I may need to have someone other than myself pickup my prescriptions. I am aware that they will need picture ID along with my signature on this authorization.

I would like _____ to pickup my prescriptions.

This authorization permits the practice to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

All Medical Needs and Care unless otherwise specified

I have received a copy of Amherst Medical Associates LLP's Notice of Privacy Practice.

This authorization will expire on: Until Further Notice
 Specify Date: _____

The practice (will will not) charge a fee for this: Estimated Cost: \$ _____

I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization.

When my information is used or 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 the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the practice address listed above.

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Patient's Name (Print) Date

Print Name of Patient or Legal Guardian