TRI-COUNTY FAMILY MEDICINE ASSOCIATES
ONE SCHOOL STREET, SUITE 107
GOWANDA, NY 14070
PHONE: (716) 241-7067 FAX: (716) 241-7197

JAMES E. WILD, M.D.
BURROUGHS, RPA-C

DANA P. ANDERSON, M.D. AMY-JO
MALLORIE KEICHER, RPA-C

Name of doctor or facility to release records: _____

Address: _____

Phone: _____

Fax: _____

Release records to: Tri County Family Medicine, One School Street, Suite 107 Gowanda, NY 14070
Fax: 716-241-7197

Patient Name: _____ **D.O.B.:** _____

Address _____

( ) I hereby authorize and request that you release all medical records in your possession, concerning my illness and/or treatment during the time period from _____ to _____. Do release HIV/AIDS and/or sexually transmitted disease related and/or drug/alcohol abuse/ treatment information. I understand that this is a duel release inclusive of sensitive medical information including HIV.

( ) Send only the following selected items: _____

_____

I understand that my consent to obtain information will expire in one year, and that I may withdraw this consent in writting at any time.

Signed: _____

Date: _____ **Relationship (if other than self):** _____

Witness: _____

This information has been disclosed to you from confidential records that are restricted by law. Federal law prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. Any unauthorized further disclosure in violation of federal law may result in a fine and/or jail time. A general authorization for the release of the medical or other information is not sufficient authorization for further disclosure.