UB|MD NEUROLOGY

UBMD Neurology
HIPAA Form

This authorization for use or disclosure of my health information is required by state or federal law

Patient Name:_____

Date of Birth:_____

Name of person/ organization releasing information:

☐ UBMD Neurology at 1001 Main Street, 4th Floor, Buffalo, NY 14203
Phone: 716.829.5050 | Fax: 716.829.5051

☐ UBMD Neurology at 5851 Main Street, Williamsville, NY 14221
Phone: 716.932.6080 | Fax: 716 332.4245

To release my health information to:
Example: Family Member, Primary Doctor, Specialist Doctor

_____

_____

_____

_____

_____

_____

Patient Signature:_____ Date:_____

Patient Representative:_____

Relationship to Patient:_____

For more:
ubmd.com

A MEMBER OF

UB|MD PHYSICIANS' GROUP

Conventus
1001 Main Street, 4th Floor
Buffalo, New York 14203
716.829.5050

5851 Main Street
Williamsville, NY 14221