UB|MD NEUROLOGY

UBMD Neurology
Record Request 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:

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To release my health information to:

☐ 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

Patient Signature:____

Date:____

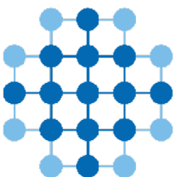
Patient Representative:_______________________________________

Relationship to Patient:_______________________________________

For more:

ubmd.com

A MEMBER OF



UB|MD
PHYSICIANS' GROUP

Conventus
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Williamsville, NY 14221