Mark E. Swetz MD, PC
Family Practice

3065 Southwestern Blvd.
Orchard Park, NY, 14127
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AUTHORIZATION TO RELEASE HEATH CARE INFORMATION

Patient's Name: _____ Date Of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I request and authorize _____ *to release health care*

(Name of healthcare provider)

information of the patient named above to: (X- indicates requested history records)

Name: **Dr. Mark E. Swetz MD, PC**

Address: **3065 Southwestern BLVD**

City: **Orchard Park** State: **NY** Zip Code: **14217**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ Current problem/ Medicine List (Face Sheet)

☐ Immunization Record/ Growth Chart

☐ Last Colonoscopy Report

☐ Last Mammogram Report/ Pap Smear Report

☐ Last Cardiac Stress Test

☐ CT/MRI/Ultra Sound Reports of past two(2) years

☐ Last CBC, CMP, FLP, HBA1C, Thyroid Profile, PSA, Urinalysis, Digoxin Level, PT/INR if such testing has been done.

☐ Last H & P Report

☐ Last Dexa Scan Report

☐ Other: _____

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Parent/Guardian Signature: _____ Date Signed: _____

Witness Signature: _____ Date Signed: _____