In Health Family Medicine

96 COURT STREET

PLATTSBURGH NY, 12901

(P)518-562-2369

(F)518-562-2263

**Authorization to Release Medical Information**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be released From:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Records to be sent to:**\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be released**:

\_\_\_\_\_ Most recent 2 years of pertinent information (chart notes, labs, x-ray, special tests)

\_\_\_\_\_ All medical Records

\_\_\_\_\_ Specific Information (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose for which the disclosure is being made:**

\_\_\_\_ Transfer of Care \_\_\_\_ Personal \_\_\_\_ Collaboration of care

**Patent Authorization:**

I understand my records may contain information regarding the diagnosis or treatment of HIV-AIDS, sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric Treatment, I give my specific authorization for these records to be released

\*Exclude the following information from the records released (Please initital)

\_\_\_ Drug/alcohol abuse/treatment & Diagnosis \_\_\_ Sexually Transmitted disease

\_\_\_ HIS/AIDS diagnosis/treatment/testing \_\_\_ Mental Illness or psychiatric diagnosis/treatment

**Patient Rights**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the privacy notice to patients posted at the facility where the information is being released. I understand that once the heath information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which it may no longer be protected under privacy laws.

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Signature Date