



2 Coulter Road
Clifton Springs NY 14432

Attached are the release of information documents required to have a copy of your medical record(s) released.

Please be sure to print, complete, sign and date the necessary form(s).

All completed release(s) can be mailed to Health First Family Medicine at the above address or faxed to 315-462-3336



Authorization for Release or Use of Medical Information

Patient Name: _____ Social Security # _____

Date of birth: _____ Medical Record # _____

<input type="checkbox"/> I authorize Health First Family Medicine to release information TO: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone # / Fax # (include area code) _____ Attention	<input type="checkbox"/> I authorize Health First Family Medicine to obtain information FROM: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone # / Fax # (include area code) _____ Attention
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Purpose for this request: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Healthcare | <input type="checkbox"/> Medicare Eligibility | <input type="checkbox"/> SSI/SSD Application |
| <input type="checkbox"/> Insurance Coverage | <input type="checkbox"/> Medicaid Eligibility | <input type="checkbox"/> Disability Determination |
| <input type="checkbox"/> Patient Request | <input type="checkbox"/> Legal Request | <input type="checkbox"/> Other – specify _____ |

Type of information requested: (check all that apply and **MUST** include date(s) of service)

- | | | |
|---|---|---|
| <input type="checkbox"/> X-Ray reports | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Laboratory test results |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Progress notes | <input type="checkbox"/> Date of service _____ |
| <input type="checkbox"/> Other (please specify) _____ | | |
| <input type="checkbox"/> Complete medical record from: _____ to _____ | | |

Information that I wish NOT to have disclosed includes:

I understand that:

- The requested information may contain alcohol, drug abuse, psychiatric, mental health, HIV testing, HIV results or AIDS information. *special forms required.
- I may refuse to sign this authorization and that it is strictly voluntary.
- My right to Healthcare treatment, payment, enrollment or eligibility for benefits is not conditioned on this authorization.
- I may revoke this authorization at any time by submitting a written request to the Privacy Officer, except where disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information state above could be redisclosed.
- There may be a charge for the requested copies of the records.
- This authorization will remain in full force and effect until it expires 90 days from the date of this authorization or _____ (insert date)
- I have read the above and authorize the disclosure of the protected health information as stated. I also acknowledge that I may receive a copy of this form as requested.

Signature of Patient or Representative _____ Date: _____

Relationship to patient (if requestor is not the patient) _____

Authorization for Release of Health Information and Confidential HIV-Related Information*

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

- I consent to disclosure of (please check all that apply):
- My HIV-related information
 - My non-HIV health information
 - Both (non-HIV health and HIV-related information)

Name and address of facility/person disclosing HIV-related information: _____ _____
Name of person whose information will be released: _____
Name and address of person signing this form (if other than above): _____ _____
Relationship to person whose information will be released: _____ _____
Describe information to be released: _____
Reason for release of information: _____
Time Period During Which Release of Information is Authorized: From: _____ To: _____
Exceptions to the right to revoke consent, if any: _____ _____
Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences): _____ _____

Please sign below only if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.	
Signature _____	Date _____

*** This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.**

**Authorization for Release of Health Information
and Confidential HIV-Related Information***

**Complete information for each facility/person to be given general information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV-related discrimination in housing, employment, health care and other services. For more information, call the New York City Commission on Human Rights at (212) 306-7500 or the NYS Division of Human Rights at 1-888-392-3644.

My questions about this form have been answered. I know that I do not have to allow release of my health and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release health and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

If legal representative, indicate relationship to subject:

Print Name _____

Client/Patient Number _____

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Name and address of facility/person to be given general health and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

If any/all of this page is completed, please sign below:

Signature _____ Date _____
(SUBJECT OF INFORMATION OR LEGALLY AUTHORIZED REPRESENTATIVE)

Client/Patient Number _____

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