Generic Authorization to Release Protected Health Information

Adirondack Health
2233 State Route 86, PO Box 471
Saranac Lake, NY 12983

Patient Name: _____ Date of Birth: _____

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

Phone Number: _____

Purpose:

☐ Personal use ☐ Transfer of care ☐ Continued Patient Care ☐ Attorney/Legal

☐ Other: _____

Information Requested:

☐ Last 3 years of visits ☐ Medication Records ☐ Laboratory reports _____

☐ Record of specific visits _____ ☐ Immunization Records ☐ X-Ray, MRI, CT _____

☐ Entire medical record ☐ Other: _____

Physician Practice/Organization Authorized to <u>Release</u> Information

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Person/Physician Practice/Organization Authorized to <u>Receive</u> Information

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

<u>Notice to recipient:</u> This information has been disclosed to you from medical records that are protected by Federal and State regulations governing confidentiality of Alcohol and Drug Abuse patient records, 42 C.F.R Part 2 and/or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R Pts. 160 and 164 and cannot be disclosed or re-disclosed without written consent unless otherwise provided for in the regulations.

The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I have the right to revoke this authorization at any time and this must be done in writing. Such revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to requests from Government Agencies, Health Insurance Companies, certain Law Enforcement Officials and others who are entitled to information without authorization under HIPAA, Federal Regulations and State Regulations. Any disclosure of information has the potential for unauthorized disclosure or re-disclosure.

_____ _____

Signature of Patient, Parent, Legal Guardian or Health Care Proxy Date

Relationship to Patient _____

This authorization will expire in 6 months or on _____ Requests for records created after this date require a new authorization.