Family Health Network of Central New York, Inc.

Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____-_____-_____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize _____ to release information from my medical record as indicated below to:

TO:	**FROM:**
NAME: _____	NAME: _____
ADDRESS: _____	ADDRESS: _____
CITY: _____ STATE: NY ZIP: _____	CITY: _____ STATE: ____ ZIP: _____
PHONE: _____ FAX: _____	PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

	DATES:		DATES
☐ History and physical exam	_____	☐ X-ray reports	_____
☐ Progress notes	_____	☐ Other	_____
☐ Lab reports	_____		_____

I hereby authorize _____ to release information from my medical record as indicated below to:

I specifically authorize the release of information relating to:

☐ Substance abuse (including alcohol/drug abuse)

- **This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder except as provided at §§2.12(c)(5) and 2.65.**

☐ Mental health (including psychotherapy notes)

☐ HIV-related information (AIDS related testing)

- **This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not, except in limited circumstances set forth in this part, sufficient authorization for further disclosure. Disclosure of confidential HIV information that occurs as the result of a general authorization for the release of medical or other information will be in violation of the state law and may result in a fine or a jail sentence or both.**

X _____ _____
SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN DATE

(CONSENT FOR INFORMATION, WITHIN THIS BOX ONLY, EXPIRES ONE YEAR AFTER THE DATE WRITTEN ABOVE)

(See reverse)

Revised: 05/24/10; 07/11/12; 11/20/12; 11/21/13; 02/22/2016, 02/2018, 04/2019

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PURPOSE OF RELEASE: ☐ Changing physicians ☐ Consultation/second opinion ☐ Continuing care
☐ Legal ☐ School ☐ Insurance ☐ Workers Compensation
☐ Other (please specify): _____

1. I understand that this authorization will expire on _____ (days or condition) after I have signed the form. (Can be up to one year if not conditioned)

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and the revocation will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

4. I understand that I am being requested to release this information by _____ for the purpose of:

   _____

   _____

   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.

5. I understand that in compliance with New York State statute, I am entitled to one free copy of my medical records every 12 months. If I request a second copy in the 12 month period, I will pay a fee of $5.00. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment, or if requested by and sent to an attorney.

For records not being sent to another medical provider, please complete questions 6 and 7 below.

6. I wish to receive ☐ a hard copy ☐ an electronic copy

7. I wish to have the record delivered:
   ☐ Will be picked up at the health center ☐ by me ☐ by _____
   Name of individual authorized to pick up records
   ☐ Mailed to the following address: _____
   ☐ Email to the following email address: _____
   I understand that if I request the record be emailed, it will not be encrypted and there is a risk that my Protected Health Information could be read or accessed by a third party while in transit.

_____ ____ _____
SIGNATURE OF PATIENT DATE

_____
PRINTED NAME OF PATIENT

OR

_____ ____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

_____ _____
PRINTED NAME OF PARENT/LEGAL GUARDIAN RELATIONSHIP TO PATIENT

Revised: 05/24/10; 07/11/12; 11/20/12; 11/21/13; 02/22/2016, 02/2018, 04/2019

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_____ ____ _____

RECORDS RECEIVED BY DATE

FOR OFFICE USE ONLY

Date request filled: _____ By: _____

Identification presented: _____

Fee Collected: $ _____

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