Family Health Network
Part of Your Community, Part of Your Life

Photo ID required for records to be picked up.
Witness to ID :_____

AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

Patient Information

Name: _____ DOB: ____ / ____ / _____
Phone: _____
Address: _____

Release Records From

Facility/Provider Name: _____
Address: _____
Telephone Number: _____ Fax Number: _____

Release Records To

Facility/Provider: **Family Health Network of CNY, Inc.**
85 South West St.
Homer, NY 13077
Telephone Number: 607-753-3797 Fax: 607-753-6677

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDSRELATED INFORMATION only if I place my initials on the appropriate line in item 5. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 5, I specifically authorize release of such information to the person(s) indicated above.
2. With some exceptions, health information once disclosed may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

Records Requested (check all that apply)

☐ Complete Medical Record ☐ Office Visits ☐ Imaging Reports
☐ Lab Reports ☐ Consultation Notes ☐ Other:

Date Range: From ____ / ____ / _____ to ____ / ____ / _____ *if no dates are listed this authorization will expire one (1) year from the date signed.*

Purpose of Disclosure (check all that apply)

☐ Continuation of Care / Treatment ☐ Patient Request ☐ Insurance/Billing purposes
☐ Legal ☐ Transfer of Care / Changing Physicians ☐ Other: _____

If changing physicians: FHN values your feedback, please let us know your reason for leaving so we can work to improve the experience.

_____

5. Drug, Alcohol, HIV and Mental Health information contained in the parts of the records indicated above **will only be released through this authorization if indicated by initialing in corresponding boxes below**:

☐ Mental Health ☐ HIV/AIDS ☐ Substance Abuse

Patient / Legal Representative Signature: _____
If signed by a personal representative, documentation of legal authority may be required.
Printed Name & Relationship (if applicable): _____ Date: _____