Patient Health Information Release Authorization

PATIENTS FULL NAME *hereby authorize* MEDICAL FACILITY or PHYSICIAN NAME

to disclose my health information under the terms described below. Pursuant to this authorization, my health information may be disclosed to, and used by, the following individual or organization.

PLEASE **CAREFULLY** CHECK **ONE**

☐ **My Self** *(Records will be mailed to your home address)* ☐ **OTHER** *(Please detail below)*

NAME AND ADDRESS OF **OTHER** INDIVIDUAL OR ORGANIZATION YOU ARE AUTHORIZING YOUR HEALTH INFORMATION BE DISCLOSED TO:		
Name: CAPITALCARE_PEDIATRICS SCHENECTADY		
Address: 700 MCCLELLAN STREET		Apt/Ste #:
City: SCHENECTADY	State: NY	Zip: 12304

Specific information to be used and/or disclosed:

☐	**All** medical records			
☐	**All** records regarding treatment for the following condition or injury:			
		Dated From		Dated To
☐	Specific 'Progress Notes':			

Please state the purpose for this request:

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING AT THE BOTTOM

I understand that if my records contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome **(AIDS)** or human immunodeficiency virus **(HIV)** related information, such information will be released pursuant to this authorization. Confidential HIV related information is any information indicating that an HIV test was done; HIV virus is present; HIV related illness or AIDS; or any information which could indicate that a person has been potentially exposed to HIV. I also understand that if my records contain information concerning **Drug, Alcohol** abuse and/or treatment, or behavioral, mental health services or **Psychiatric** treatment, such information will be released pursuant to this authorization. **Unless otherwise revoked, this authorization will expire in 90 days**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical facility. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 90 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the medical facility or ROI Solutions, Inc. at 1-(800) 281-7001.

Exceptions to the above, I do not authorize the release of the following:

☐ Mental Health

☐ HIV/AIDS

☐ Substance Abuse/Alcohol Abuse

DOB: / /		Phone: ( ) -	
SS: - -		Fax: ( ) -	
Address:			City
State	Zip:	Email:	
X		Date:	
Patient Signature/Authorized Representative:		Relationship to Patient:	

THIS AUTHORIZATION WILL BE CONSIDERED INVALID WITHOUT APPROPRIATE SIGNATURE AND THE PATIENT DOB AND SS#. Social Security Number only used for identification purposes.