PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize:

Provider / Facility Name: ______________________________ Phone: ____________________

Location: ______________________________________ Fax: ____________________

To use and/or disclose certain protected health information (PHI) about me to:

Dr. ____________________________
Partners in Family Medicine
101 Jordan Rd, Ste 104 – Troy, NY 12180
Phone: (518) 274-0024 | Fax: (518) 274-9487

1. **Specific Information to be Released:**

☐ Option 1: Entire medical record from (insert date) ____________ to (insert date) ________ (if not specified, all dates)

PLEASE NOTE: ***This includes any and all HIV-related information, drug and alcohol treatment, and mental health information. If you do not wish to have this information disclosed, please indicate below.***

DO NOT INCLUDE: ☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV-Related Information

☐ Option 2: Include only:

☐ Prescriptions ☐ Office Notes ☐ Lab Results ☐ Billing

☐ Other (Please be specific):____

____

PLEASE NOTE: ***This includes any and all HIV-related information, drug and alcohol treatment, and mental health information. If you do not wish to have this information disclosed, please indicate below.***

DO NOT INCLUDE: ☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV-Related Information

2. **Please initial:**

__________I understand that this authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV-RELATED INFORMATION unless I exclude this information above. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

3. **The Reason for Release of Information:** ☐ At request of individual ☐ Other: ____________________

4: **Expiration Date:** This authorization will expire on ______________________________

{Expiration Date or Defined Event} If no date is given, this authorization shall expire one year from the date signed below.

I understand that Community Care Physicians, PLLC will not receive payment or other remuneration form a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Community Care Physicians, PLLC In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

______________________________ ____________________
Patient's Name Patient's Date of Birth

______________________________ ____________________
Signature of Patient or Legal Guardian Date

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Name of Legal Guardian (if applicable)