COMMUNITY CARE PHYSICIANS

GENERAL

PATIENT HIPAA AUTHORIZATION

THIS IS NOT A MEDICAL RECORDS REQUEST FORM. TO REQUEST A COPY OF YOUR RECORDS, PLEASE SEE THE FRONT DESK OR VISIT www.communitycare.com

Patient's Full Name (Last, First) **Patient's Date of Birth**

Step 1: Who Can Receive Your Information?

I, the undersigned, being the patient/parent/legal guardian/personal representative, authorize the above-named patient's health information to be **RELEASED or SHARED BY Community Care Physicians** to the following:

Name(s)/Entities (please include address and phone number):_____

_____

_____

Step 2: What Can We Share?

I authorize the release of the following health information:

☐ Entire Medical Record from (insert date) _____to:_____(If no dates are listed, then the entire chart may be released)

Or, instead of releasing all my health information, please release only the following information: (check the applicable boxes below)

☐ Billing Records ☐ Last Office Note ☐ Immunizations/Vaccinations ☐ Radiology Reports ☐ Laboratory Reports

☐ Medications ☐ Last Physical ☐ Other: _____

My Sensitive Information:

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 below. 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.

DO NOT INCLUDE MY:

☐ **Alcohol/Drug Treatment** ☐ **HIV-Related Information** ☐ **Mental Health Information**

Reason for Release:

☐ At request of patient ☐ Transferring Care out of CCP to a New Provider ☐ Legal Request ☐ Other:_____

Step 3: When Does this Authorization Expire?

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 will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. This authorization may include disclosure of information relating to all Community Care Physicians' offices I have visited. I do not have to sign this authorization in order to receive treatment from Community Care Physicians. 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.

_____ _____

Print Name of Patient or Legal Guardian ***Signature of Patient or Legal Guardian***

Date: _____ ***Relationship to Patient***: _____

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REQUEST FOR COPY OF MEDICAL RECORDS

verisma

Patient Name:_____ DOB:_____

Street Address:_____ City, State, Zip:_____

Email Address: _____ Telephone:_____

Step 1: Which Records Are You Requesting?

Option 1

If No Dates are Given then All Records will be Released

☐ Entire Medical Record from these Dates:

_____ to _____

Option 2

Only the Following Specific Information (Check all that Apply)

☐ Billing Records ☐ Laboratory Reports
☐ Last Office Note ☐ Medication(s)
☐ Immunizations ☐ Other:_____

From:_____ to:_____

Please Do Not Include the Following from this Release:

☐ HIV Information
☐ Drug/Alcohol Information
☐ Mental Health Information

Step 2: Who Will Receive These Records?

☐ Myself

☐ Someone Else

Name: _____

STOP: Where is your HIPAA Authorization or other Supporting Documentation? (ex: POA, HCP, or Executor of Estate)

☐ Attached to this request ☐ Already in the Chart

Relationship to Patient: _____

Step 3: How Would You like These Records Prepared?

☐ Paper Copy Mailed to the Address Provided Above or to: _____

☐ CD Copy Mailed to the Address Provided Above or to: _____

☐ Emailed to the Email Address Provided Above or to: _____

☐ Faxed to the Following Number: _____ **Please Note we can Only Fax up to 40 Pages of Records**

Step 4: What is The Reason for the Release?

☐ Treatment
☐ Transferring Care out of CCP to a New Provider
☐ Legal Request
☐ Other: _____

Step 5: Important Information

a. I understand that the content of my file is not medical advice and is not to be used or relied on for diagnosis or treatment. The content does not take the place of instructions or advice from my doctor or health care provider. I will talk to my doctor or other health care provider before making any major health care decisions based on this electronic file.

b. I understand that the information disclosed pursuant to this request may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.

c. I understand that records in electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of CCP once it is in my possession. By requesting records in this format, I am knowingly and voluntarily assuming this risk and all consequences, losses and damages that might result.

d. I understand that this is not a general authorization for the release of my medical information. Specifically, I understand that I may choose not to have my HIV-related information, my alcohol and drug treatment, and my mental health information disclosed.

Step 6: Payment

Depending on the type of medical record request, you may receive an invoice and be charged a fee from our medical records partner, **Verisma**, in accordance with the NYS fee schedule.

Signature of Patient or Requestor: _____ Date: _____