# PATIENT HIPAA AUTHORIZATION

# TO SEND RECORDS TO COMMUNITY CARE

| | |
|---|---|
| **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 **SENT TO** the following Community Care Physicians location:

**Pediatrics Schenectady**
**700 McClellan Street**
**Schenectady, NY 12304-5637**
**P: 518-372-5637 F: 518-372-1384**

## Step 2: Where is Your Information Coming From?

Name/Entity:_____Phone: _____

Address/City, State, Zip:_____Fax:_____

## Step 3: What Can CCP Receive?

**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 to a CCP Provider ☐ Other:_____

## Step 4: 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. 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. 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***: _____