



# PATIENT HIPAA AUTHORIZATION TO SEND RECORDS TO COMMUNITY CARE

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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:

**Community Care Regional Podiatry  
and Surgery**  
2546 Balltown Road, Suite 200  
Niskayuna, NY 12309  
P: 518-454-9140 F: 518-454-9141

### 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: \_\_\_\_\_