Authorization to Release Healthcare Information

This office uses electronic records. ***Please FAX records if possible to 315-703-1875***

(This release expires 90 days from the date of signature or upon written notification)

Patient's Name: _____

Date of birth: ____/____/_____ Social Security Number: _____/____/_____

Other name under which records may be filed: _____

Patient's address: _____

City: _____ State: _____ Zip: _____

Patient's phone number: (_____) _____-_____

I specifically authorize any current employee of _____

to release my Medical Records as described on this form to the recipient listed below. I understand that when the information is released it may be subject to re-disclosure by the recipient and may no longer be protected Personal Health Information (PHI). **I understand there may be a charge for this service.**

Purpose of the information to be released: _____

Please release my Medical Records to:

Name: My Country Doc

Address: 5695 Bull Hill Road

Lafayette, NY 13084

Please confirm whether you want to receive and be charged for copies of: (Please initial the appropriate line, if no line is initialed, records generated in this office only will be provided)

_____ The records generated in this office only.

_____ The records generated in this office and copies of other health care professional's records, if they are in our possession. **(We cannot guarantee that these records are complete)**

_____ Other specific dates of treatment or specific parts of the record: _____

Patient Signature: _____ Date: _____/_____/_____

(or legally authorized representative with description of authority)

Relationship to Patient if legal representative: _____

I understand that my express consent is required to release my healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. I specifically request the release of medical information pertaining to HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. Pinnacle Family Medicine is specifically authorized to release all health care information for such diagnosis, testing or treatment.

Patient Signature: _____ Date: _____/_____/_____

(or legally authorized representative with description of authority)

Relationship to Patient if legal representative: _____