415 HOOPER ROAD
ENDWELL, NEW YORK 13760
(607) 754-3863
www.endwellfamily.com

BRUCE T. BOWLING, MD
CAITLYN BURFORD, MD
KIMBERLY M. DESANTIS, MD
MICHAEL T. FEDERICO, DO
DEMETRIOS GASPARIS, MD
LAZARUS B. GEHRING, MD
JONATHAN A. HARRIS, MD
JAMES C. HOLLER, MD
ERIC LORRAINE, DO
REKHA S. PATEL, MD
SUCHET R. PATEL, MD
JOHN S. PERRY, MD
DUNCAN SZE-TU, MD
MICHAEL H. TUNICK, DO
GLORIA J. BLOCK, FNP-C
ANN M. LAMARCA-MAJOR, FNP-C
SUSAN M. PUGLISI, FNP-C

VICTOR A. ELINOFF, MD, RETIRED 2014

GLENN W. TYMESON, MD, 1918-1984

Authorization for Use or Disclosure of Protected Health Information

Name: ___________________________________ Date of Birth: ______________

Address : _________________________________ Phone # ____________________

I authorize Dr./Provider _________________________________
Address: _________________________________
____

To (check all that apply):
____ release my protected health information complete
_____ including HIV
_____ including alcohol/drug information
_____ including mental health information
____ release my protected health information with the exception of: ______________
____

Release to: Name/Dr. ______________________________
Address: ______________________________
____

I understand that if my records contain information about alcohol and drug abuse, mental health treatment and/or HIV/AIDS status, I authorize the Practice to release such information as part of my medical record only if I place my initials on the appropriate line as set forth above. The disclosure of any part of the medical record deemed to be "psychotherapy notes" will require a separate authorization.

This **protected health information** is being used or disclosed for the following purposes:
(___) Records to Specialist concerning treatment for _____________________________
(___) Permanent Transfer Out of the Practice
Reason: _____ Insurance Change/Type of Insurance _____________________
_____ Moving out of area
_____ Dissatisfied with Care
_____ Billing Issues

This authorization shall be in force and effect until 60 days after the date of signature at which time this authorization to use or disclose this protected health information expires unless revoked by request earlier.

Check here ________ if you want your records to be transferred in electronic format (by CD). By checking this option, I under that I will be charged a $20 fee per CD. Please note that not all other Facilities will accept records on CD and we will be unable to send them on CD in this case. If I do not check this option, records will be mailed in paper form with a fee of $.75 per page or will be faxed. The Practice will waive the fee for a first copy being sent to another Medical Facility.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Endwell Family Physicians, 415 Hooper Road, Endwell, NY 13760. I understand that a revocation is not effective to the extent that my provider has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use of disclosure requested under this authorization may result in direct or indirect reimbursement to my provider from a third party.

My provider will not withhold my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Unless required by law or you specify above to the contrary, it is the policy of EFP to review for release your complete medical record as contained in our EMR in order to facilitate your care. This may include medical documentation in our possession which may have been provided to use or created by another medical provider. It is the policy of Endwell Family Physicians to only send the last five (5) years of medical information.

If any further information is needed please contact the office at (607) 754-3863.

_______________________________________   ____

Signature of Patient or Personal Representative   Print Name of Patient or Personal Representative

____________________   ____

Date   Description of Personal Representative's Authority

____

Party Witness   (required to release records to recipients other than providers)

** Notary Public (only needed if information is for court records)

State of New York, County of Broome
On the ___ day of ___________, 20_____before me personally came _______________
to me known to be the individual who executed the foregoing instrument and acknowledged that he/she executed the same.

____

Notary Public

- *A copy of this form will accompany your records. Copy offered to patient.*