Authorization for Use or Disclosure of Protected Health Information

Name: ___________________________________ Date of Birth: ______________

Address : _________________________________ Phone # ____________________

I authorize Dr. _________________________________
Address: _________________________________
____

to (check all that apply):
____ release my protected health information complete
_____ including HIV
____ release my protected health information with the exception of: ______________
____

to: Name/Dr. ____
Address: ____
____

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.

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.

Over

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.

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.

The use of disclosure requested under this authorization will result in direct or indirect reimbursement to my provider from a third party.

It is the policy of Endwell Family Physicians to only send the last 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 (if needed)

** 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.