Authorization for Use or Disclosure of Protected Health Information

Patient Name:________________________________

Address:____________________________________

DOB:____________ Phone #:___________________

I, or my authorized representative, request and authorize the release of my health information as set forth on this form.

Release Information **From**: ____ Endwell Family Physicians, LLP
____Other Provider
- Name of other provider:_________________________________
- Address:____

Release Information **To:** ____ Endwell Family Physicians, LLP
____Other Provider
- Name of other provider:_________________________________
- Address:____

I request that you release the following: (**initial** next to all that apply):
____ release my entire medical record (all protected health information)

-OR-
____ release only the following items from my medical record (please specify):______________________

____

For the following to be included in your record release, please **initial** next to the desired item below:
_____ including HIV
_____ including alcohol/drug information
_____ including records from mental health programs

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
_____ Other ____

I understand that if my records contain information about alcohol and drug abuse, mental health treatment from a mental health program 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 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.

Fees: The practice will waive the fee for the first copy being sent to another medical facility. Records released directly to patients will be subject to a fee of $6.50, regardless of form (paper, CD, etc). Records released to third parties will be subject to a fee of $.75/page, up to a maximum of $50, regardless of form.

Check here ________ if you want your records to be transferred in electronic format (by 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 or will be faxed.

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.

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.

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

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