Finger Lakes Dermatology

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Date of Birth:_____

Patient Address:_____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in Item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in item 8, I specifically authorize release of such information to the person(s) indicated in item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose with out my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-329-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary; I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this information:

_____

_____

6. Name and Address of Person(s) toWhom this information Will be Disclosed:

_____

_____

7. Purpose for Release of Information:

_____

8. Unless previously revoked by me the specific information below may be disclosed until _____ (Exp. Date)

Check Items to be released:

[ ] Problem List
[ ] Medication List
[ ] Allergy List
[ ] Vitals
[ ] Immunizations
[ ] Progress Notes/History & Physicals
[ ] Consults
[ ] Lab Results
[ ] Radiology/Test Results
[ ] Therapy Results
[ ] Communications
[ ] Insurance/Billing information
[ ] Advance Directives
[ ] Other: _____
_____
[ ] All Records from (insert dates):
_____ to _____

Check which will be included and initial:

[ ] Records from Alcohol/Drug Treatment Programs _____
[ ] Records from Mental Health Programs _____
[ ] HIV/AIDS-related information _____

9. If not the patient, name of person signing form: _____
10. Authority to sign on behalf of patient: _____

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

X_____

Signature of Patient or Representative Authorized by LAW Date