AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name____ **DOB** ___________________
Patient Address____

Please release my medical records from:
____ ("Previous Healthcare Provider"),
with an address at
____
Phone: ______________________________Fax:_______________________________________

Please disclose to **Trumansburg Family Medicine** ("Recipient"), with an address at **4435 Seneca Road, Trumansburg, New York 14886**, **Fax # (607) 387-4354, Telephone (607) 387-5707** the following specific health information:

____Office Notes for past 2 years **OR** ____Office Notes from ______ to _________
____Immunization History
____Problem List
____Past Medical, Family, and Social History
____Medication List
____Last Mammogram & Last Pap
____X-ray reports - All
____Laboratory test results for past 2 years
____EKG
OR
____ Entire Medical Record

Drug, Alcohol, HIV and Mental Health Information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

Do Not Release: ____Drug/Alcohol ____HIV ____Mental Health/ (Psychiatric)

This authorization is granted for the following purpose(s): **Treatment purposes**
This authorization is valid until ____ / ____ / _______. **If blank, expiration is one year after date of signature.**

This authorization may be revoked by the undersigned individual at any time, by submitting a written notice of revocation to Provider. However, any revocation shall not apply to the extent that Provider has taken action in reliance on this authorization. The information disclosed pursuant to this authorization may be disclosed again by Recipient and if so, may no longer be protected by Provider's privacy practices or Federal privacy regulations.

By signing my name below, I hereby acknowledge that I have read and fully understand this form. I understand that medical treatment, payment, enrollment in a health plan and eligibility for benefits may not be conditioned on my signing this authorization. I acknowledge that I may refuse to sign this authorization and that I am signing this authorization voluntarily.

This section is to be completed if authorization is being given by the Individual	
____________________________________ Name of Individual Date of Birth ____ / ____ / ________	____________________________________ Signature of Individual Date signed ____ / ____ / _________

This section is to be completed if authorization is given by a Personal Representative	
____________________________________ Name of Personal Representative Date signed ____ / ____ / ________	____________________________________ Signature of Personal Representative ____________________________________ Description of Authority to act as Personal Representative of the Individual (e.g., Guardian, Attorney-in-fact)