

AUTHORIZATION TO RECEIVE 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.

<i>This section is to be completed if authorization is being given by the Individual</i>	
Name of Individual _____ Date of Birth ____ / ____ / _____	Signature of Individual _____ Date signed ____ / ____ / _____

<i>This section is to be completed if authorization is given by a Personal Representative</i>	
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) _____