

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ **DOB** _____

Patient Address _____

This form authorizes the Trumansburg Family Health Center ("Provider"), with an address at 4435 Seneca Road, Trumansburg, NY 14886 to disclose to:

Name: _____

Address: _____

Fax# _____ Telephone# _____

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

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.

Only **ONE** of the following sections must be completed.

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