AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

I authorize: MADISON IRVING PEDIATRICS
475 Irving Ave., Ste. 210
Syracuse, NY 13210
Ph: (315) 471.2646 Fax: (315) 471.1762

☐ **SEND** my medical records to: ☐ **OBTAIN** my medical records from:

Person/Organization Name: _____

Address: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

The Information to be disclosed from my health record: (check all that apply)

□ Entire Medical Record- including Previous Provider Records

□ Information Related to (specify)_____

□ Time period of _____ to _____

□ Other (specify)_____

If you would like the following information disclosed, check the applicable box/boxes below:

□ Alcohol/ Drug Abuse Treatment □ Sexually Transmitted Diseases

□ HIV/AIDS- related Treatment □ Mental Health *(other than Psychotherapy notes)*

The purpose or need for disclosure is:

□ Transfer Medical Care □ Personal Use □ Attorney □ Other (Specify)_____

› I understand that my medical and/or billing information may be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of your information.
› I understand and am aware of security risks associated with unsecure transmission of my Personal Health Information (PHI) by fax. I accept this security risk and request to have my PHI sent by the method indicated above.
› I understand my medical records may contain information relating to Alcohol/Substance abuse, Mental Health, STD, and/or HIV/AIDS related information. This information will not be released unless the appropriate boxes have been checked pertaining to this information.
› I understand that I have the right to Inspect and/or receive a copy of the information described on this authorization form by completing a request for access form.
› I understand I have the right to receive a copy of this authorization form after I have signed it.
› I understand I may revoke this authorization in writing, at any time.
› This authorization will terminate ONE YEAR from the date of my signature.

_____ _____
Signature of Patient or Legal Guardian Date

Printed Name: _____ Relationship: _____