

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

I authorize:

MADISON IRVING PEDIATRICS
6711 Towpath Rd., Ste. 235
East Syracuse, NY 13057
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: _____