AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name of Patient: _____

Date of Birth: _____ Phone #: _____Medical Record #: _____

I authorize the release of the above named individual's health information as described below:

1. The following organization is authorized to make the disclosure:
   Niagara Falls Memorial Medical Center
   621 Tenth St., Niagara Falls, NY 14302

2. **Specific information to be released is as follows:**

   _____ Medical Record from (insert date) _____ to (insert date) _____

   _____ Other: _____

   Include: (indicate by initialing) _____ Mental Health Information
   _____ HIV-related Information

3. I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). A separate consent specifically authorizing the release of confidential HIV-related information is required for release of this information. My health records may also include information about Behavioral Health or Mental Health services and treatment for alcohol and drug abuse. This authorization must specifically address release of psychiatric, alcohol or drug abuse health records.

4. **Name and address of the person or organization to whom this information will be sent:**

   Name: _____
   Address: _____
   _____

5. **Reason for the release of information:**

   _____ At the request of the individual
   _____ Other: _____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months from the date on which it was signed.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy laws or regulations. If I have questions about disclosure of my health information, I can contact Health Information Management, Correspondence Unit at 278-4689.

_____ _____
Signature of patient or representative authorized by law Date

Please mail completed authorization to Niagara Falls Memorial Medical Center, Attention: Health Information Services, 621 Tenth St., Niagara Falls, NY 14302 or fax it to (716) 278-4068.

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NIAGARA FALLS
Memorial Medical Center
Niagara's Premier Health Network