

**Authorization to Release Medical/Dental Information**

**Patient:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient's Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**This authorization permits Finger Lakes Community Health (FLCH Medical Records Dept. P.O. Box 902, Ovid, NY, 14521) to:**

Receive Information From:  Release Information To:

**Healthcare Provider/Requestor:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Ext:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**This release of information is for the purpose of:**  Transfer of care  Financial  Education  Other: \_\_\_\_\_

**Specific Information for Release:**  Medical  Dental  Medical and Dental

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Pathology Reports    | <input type="checkbox"/> X-Ray Reports           |
| <input type="checkbox"/> Laboratory Reports   | <input type="checkbox"/> Consult Reports      | <input type="checkbox"/> X-Rays (Dental)         |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Itemized Bills/Payments |
| <input type="checkbox"/> Progress Notes       | <input type="checkbox"/> Emergency Room Notes | <input type="checkbox"/> Entire Record           |
| <input type="checkbox"/> Other: _____         |   |  |

- I understand that I may revoke this authorization at any time by sending a written revocation to Finger Lakes Community Health (FLCH) except to the extent that FLCH has taken action in reliance of this the authorization.
- I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release by the Receiving party and may no longer be protected by federal or state law.
- I understand that my continued or future treatment by FLCH is not conditional upon my providing or signing this authorization.
- I understand that if FLCH is the Receiving Party, I have the right to inspect or copy the health information FLCH intends to use or disclose, pursuant to this authorization and may, upon inspection, refuse to sign the authorization or may revoke this authorization if already signed.
- I further understand that correspondence, and records from other health care providers will not be released with this routine request. Please be aware there is a charge to copy and transfer records, unless you are transferring to another physician practice. There is no charge to send directly to another physician.
- This authorization is made in accordance with federal and state law and is valid for a period of one year after being executed; however, it may be revoked by me at any time by providing written notice to the above named party. A facsimile or photocopy of this document will be accepted in lieu of the original.

**Special Authorization if Applicable (an initial must be present in order to release specified information):**

\_\_\_\_\_ My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted on the signed authorization.

\_\_\_\_\_ My evaluation, testing, diagnosis or treatment concerning my mental health/ rehabilitation neuropsychological information may be released to the recipient of the signed authorization.

\_\_\_\_\_ My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted on this signed authorization.

\_\_\_\_\_ My testing, diagnosis or treatment for STDs may be released to the recipient noted on this signed authorization.

**Patient/Legal guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If Parent or Legal Guardian Print Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Finger Lakes Community Health Medical Records Phone: 607-403-0065 Fax: 315-781-8444**