Finger Lakes COMMUNITY HEALTH
Taking the time to care.

Authorization to Release Medical/Dental Information

Patient: _____ **Date of Birth:** _____

Patient's Address: _____ **Phone Number:** _____

This authorization permits Finger Lakes Community Health (601B West Washington Street, Geneva, NY 14456) to:

☐ Receive Information From: ☐ Release Information To: ☐ Share Information for Continuity of Care With:

Healthcare Provider/Requestor: _____

Address: _____

Phone: _____ **Ext:** _____ **Fax:** _____

This release of information is for the purpose of: ☐ Transfer of care ☐Financial ☐ Education ☐ Other: _____

Date range being requested: From: _____/_____/_____ **To:** _____/_____/_____

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

☐ Discharge Summary	☐ Pathology Reports	☐ X-Ray Reports
☐ Laboratory Reports	☐ Consult Reports	☐ X-Rays (Dental)
☐ History and Physical	☐ Immunization Records	☐ Itemized Bills/Payments
☐ Progress Notes	☐ Emergency Room Notes	

☐ 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:** _____

Received by: _____ **Date:** _____

Finger Lakes Community Health Medical Records Phone: 315-781-8448 Fax: 315-781-8444
Email: healthinformation@flchealth.org