ADIRONDACK HEALTH
Leading care for a healthy community
2233 State Route 86
Saranac Lake, NY 12983

Medical Record #: ________________

Authorization to Release Health Information

Patient Name: ______________________________ Date of Birth: ______________

Address: ______________________ City: ______________ State: ______ Zip: ________

Phone #: ________________ **Dates of service:** ________________

Information requested (check all applicable)

- ❑ Abstract of Medical Record
- ❑ Discharge Summary
- ❑ ER Record
- ❑ History and Physical/ Consult
- ❑ Immunization records
- ❑ Office visit - date (s) ______________ Name of provider: ______________________
- ❑ Other: ____
- ❑ Lab reports
- ❑ Operative report
- ❑ Radiology Reports
- ❑ Radiology images/CD

Purpose: ❑ Personal Use ❑ Other
❑ Transferring Care From: ____________________ To: ____________________

Medium: ❑ Paper ❑ Disc ❑ Thumb drive ❑ Mail ❑ Pick up

This is a request for Adirondack Health to disclose health information

Release information to: (please print)

Name: ____

Address: ____

Phone #: ______________________________ Fax #: ______________________

I understand that:

Under certain circumstances, I may be required to produce supporting legal documentation in cases of Custody, Proxy, Executor of Estate, etc.

The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I have the right to revoke this authorization at any time and this must be done in writing. Such revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to requests from Government Agencies, Health Insurance Companies, certain Law Enforcement Officials and others who are entitled to information without authorization under HIPAA, Federal Regulations and State Regulations. Any disclosure of information has the potential for unauthorized disclosure or re-disclosure.

____ ______________________
Signature of Patient, Parent, Legal Guardian or Health Care Proxy Date

Relationship to Patient ____

This authorization will expire in 6 months or on _________ Requests for records created after this date require a new authorization.

<u>Notice to recipient:</u> This information has been disclosed to you from medical records that are protected by Federal and State Regulations. These regulations prohibit you from re-disclosure without the written consent of the patient/parent/legal guardian or otherwise permitted by specific regulations.

Release of Information 518-897-2567 / Fax number 518-897-4575 / Health Information Management Dept. 518-897-2520