Associates for Women's Medicine

Patient Authorization for Release of Medical Information

This form authorizes the disclosure of protected health information, which may include confidential HIV-related information.

Patient Name	Date of Birth	Phone Number
Patient Address		

I authorize the release of my medical information as follow:

☐ AWM Release to name or facility below **OR** ☐ Name or facility below to release to AWM

Name or Facility: _____

Address: _____

City: _____ ***St.:*** _____ ***Zip:*** _____ ***Ph:*** _____

Attention Of: _____

Please send last TWO YEARS of office visits, lab and pathology.
Please send ALL Surgeries and Pregnancies.

For the following to be included, YOU MUST check the box of information to be disclosed and initial below.

Initials

☐ Records from alcohol/drug treatment programs _____

☐ Clinical records from mental health programs _____

☐ HIV/AIDS-related Information _____

☐ Genetic Testing _____

☐ Other

Specific Date Range: From_____ To_____

Reason for Disclosure: ☐ Primary Care/Specialist ☐ Patient Request ☐ Legal Proceedings

☐ Transfer of Care *(Reason for Transfer)*_____

Authorization will expire 12 months from the date of this authorization

PLEASE SEE THE BACK OF THIS FORM FOR IMPORTANT INFORMATION.

•TURN OVER•

Patient Signature: _____ **Date:**_____

Legal Representative: _____ **Date:**_____

Witness: _____ **Date:**_____

Village Medical Park, 792 1⁄2 North Main Street, North Syracuse, NY 13212
770 James Street, Syracuse, NY 13203
4302 Medical Center Drive, Suite 302, Fayetteville, NY 13066
Medical Center West, 5700 West Genesee Street, Suite 9, Camillus, NY 13031
Fax (315) 472-8497

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, GENETIC TESTING, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line. In the event the health information being released includes any of these types of information, and I initial the line pertaining to said information, I specifically authorize release of such information to the person(s) indicated as receiving my medical records.

2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, genetic testing, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. Associates for Women's Medicine, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. If I experience discrimination because of the release of disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 792 North Main Street, Suite 100A, North Syracuse, NY 13212

4. I do not have to sign this authorization in order to receive treatment from Associates for Women's Medicine. I have the right to refuse to sign this authorization. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure; however, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the protected health information.

Note: There is a $.75 charge per each page copied, as allowed by law, if this record is not being sent to a physician or other health facility for the continuation of care. If a person is unable to afford such a payment and can show proof of income or inability to pay, the fee will be waived. Per New York State Law, this office has ten (10) business days to comply with your request.

Requests for a minor (under age 18) should be signed by the parent having legal custody or by the legal guardian; except in situations protecting the minor's privacy as stated by NY State Health Code regulations. As a minor in New York State you may seek treatment for certain conditions without the knowledge or consent of his/her parents; in alcohol or drug abuse cases, HIV/AIDS, venereal disease, certain other contagious diseases, pregnancy, or family planning and abortion. Only the minor may have access to the medical record unless consent is specifically given to the parents or guardian to obtain information. (See Decline Above)

Requests for records of a Deceased Patient require proof of the requestor's authority as Executor or Administrator of the Estate.