ST. JOSEPH'S Physicians

Fax: 315-744-1967

Authorization for Release of Information

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) SJP may not use or disclose your health information except as provided in our Notice of Privacy Practices, without your authorization.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and I may revoke it at any time. A revocation of this authorization must be in writing and submitted to SJP Health Information Services at 5100 W. Taft Road, Liverpool, NY 13088.. I further understand that any such revocation does not apply when persons authorized to use and disclose my health information have already acted in reliance on this authorization. I understand that I may refuse to sign this authorization and that treatment or payment will not be conditioned on signing an authorization if doing so would be prohibited by Federal or NY State law. In addition, I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties if the recipient(s) on this form is not required to protect this information and such information is no longer protected by law. I understand that 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 genetic information, information about behavioral or mental health services and treatment for alcohol and drug abuse.***

Patient's Name: _____ ***DOB:***_____

Address: _____

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

I authorize the release of my medical information as follows:

[ ] SJP release to name or facility below OR [ ] Name or facility below release to SJP

Name or Facility:_____

Address: _____

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

Attention Of: _____

Description of health information to be released for dates of care _____

[ ] discharge summary	[ ] lab results	[ ] psychotherapy notes (if this is checked, use for this purpose only)
[ ] operative report	[ ] x-ray reports	[ ] summary of care
[ ] pathology report	[ ] EKG copies	[ ] Drug/Alcohol info (complete form #TRS-2)
[ ] consultative report	[ ] immunization	[ ] HIV info (complete form #DOH2557)
[ ] admission note	[ ] chronic/serious problems	
[ ] History and Physical	[ ] other: _____	

Expiration of Authorization (indicate date or event): _____

This authorization expires upon release of requested information unless otherwise stated.

Purpose of Release:

[ ] Coordination of Care [ ] Legal [ ] Insurance [ ] Disability/Worker's Compensation [ ] Other _____

I understand that I will be charged and expected to pay the full price of $ .75 cents per page for release of my records to anyone who has not directly requested these records.

_____ _____

Signature of Patient or Parent/Guardian or Other Qualified Individual *Date*

_____

If not the patient, print name and relationship to patient