OPEN DOOR
FAMILY MEDICAL CENTERS


☐ Ossining Open Door
165 Main Street
Ossining, NY 10562
Tel (914) 941-1263
Fax (914) 941-8626

☐Port Chester Open Door
& School Based Health
5 Grace Church Street
Port Chester, NY 10573
Tel (914) 937-8899
Fax (914) 937-7932

☐ Sleepy Hollow Open Door
80 Beekman Avenue
Sleepy Hollow, NY 10591
Tel (914) 631-4141
Fax (914) 631-1867

☐ Mt. Kisco Open Door
30 West Main Street
Mt Kisco, NY 10549
Tel (914) 666-3272
Fax (914) 666-3287

☐ Brewster Open Door
155 Main Street
Brewster, NY 10509
Tel (845) 279-6999
Fax (845) 279- 0908


# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby request that health information regarding my care and treatment at Open Door Family Medical Centers be released as set forth in this form in accordance with New York State Law and Privacy Rule of the Health Information Portability and Accountability Act of 1996 (HIPAA). I authorize and waive any liability or legal responsibility of the employees, staff or agents of Open Door Family Medical Centers, Inc., to RELEASE information from the medical record(s) of:

**PATIENT NAME:**_____ **MEDICAL RECORD #** _____

**PATIENT HOME ADDRESS:**_____
**Street** **Apt#** **City** **State** **Zip Code**

**DATE OF BIRTH:**_____ **SS#:**_____ **HOME PHONE #** _____ **CELL PHONE**_____

**SEND TO THE INDIVIDUAL/ORGANIZATION LISTED BELOW at the identified location checked above:**

| NAME | ADDRESS | PHONE# |
|---|---|---|

## Release the following information (Check all that apply):

---------- **PROGRESS NOTES** _____**PATHOLOGY (Pap/Biopsy)** _____ **DIAGNOSTIC TESTS (Labs. X-rays etc.)**

---------- **PHYSICAL EXAM** _____ **IMMUNIZATIONS** _____ **HIV** _____ **MENTAL HEALTH**

_____ **DRUG/ALCOHOL TREATMENT** _____ **DENTAL** _____ **PRENATAL** _____ **OTHER (Please specify):**_____

**Reason for Release:** _____

**Covering Records from (Date)** _____ **to (Date)** _____

If the requested portion of the medical record contains information pertaining to Psychiatry, Alcohol or Drug Treatment or contains HIV related information, you must specifically consent to the release of such information by initialing one or both of the following:

_____I understand that if my records contain information concerning psychiatry, drug and alcohol treatment, such information will be released pursuant to this consent. This authorization is protected by Title 42 of the Code of Federal Regulations. According to Title 42 any person who received information from the record of such a patient may not show this information to anyone else without my written permission.

_____I understand that if my records contain confidential HIV related information, such information will be released pursuant to this consent form*. **and will require an additional authorization** (NYS DOH-2557) which is required for disclosures when my medical records contain information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.

This consent will automatically expire one (1) year from the date of my signature or the date _____ contained here which is less than one year from my signature.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department at Open Door Family Medical Centers. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____
**Signature of Patient or Representative** **Requestor's Home Address, if other than patient**

_____ _____
**Relationship to Patient** **Date**

_____
**Witness**

**Office Use Only** _____ **Photo ID** _____ **Payment Received** _____ **Processed by (Medical Records Staff Name)**

**Comments:** _____

***Revised 6 2013***