Bonnie Sunday MD

General Physician PC
Phone 716 646-2590

Office Address
517 Sunset Drive

Hamburg NY 14075
Fax: 716 -646-2593

REQUEST MEDICAL RECORDS

(PLEASE PRINT)

I hereby request and authorize the following to release medical records:

_____	**General Physician**
_____	**Bonnie Sunday MD**
_____ **TO**	_____
_____	_____
FAX: _____	**FAX:** _____

PATIENT: _____**D.O.B:** _____

Under 18 years of age? ☐ **yes** ☐ **no**

***(If the patient is a minor** and the medical records contain Ob/Gyn, abortion or pregnancy related documentation, the minor's signature is required)*

Patient Home Address: _____

Home Phone Number: _____ **Cell phone:** _____

What information should be released? _____

_____

Do your medical records contain information related HIV/AIDS counseling or testing, Behavioral Health notes or other information regarding the treatment of depression/anxiety, or counseling and/or treatment of alcohol drug abuse? **If so, specific authorization is needed to release those records.** **SIGN OTHER SIDE OF THIS FORM.**

Purpose for release of medical information: ☐ **Transfer of care** ☐**Continuity of care**

Effective Date to Transfer Medical Records: _____

I understand that I have the right to revoke the authorization, in writing, at any time. (Requests to revoke an authorization must be directed to the attention of General Physician PC I understand that the two expectations to the right to revoke are: (1) where General Physician PC has acted in reliance upon the authorization; (2) if the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy. I understand that the information is disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the privacy regulations. I also understand that this authorization is effective for release of information prior to the date it has been signed and unless otherwise indicated, this authorization will expire in 90 days. I further understand that this authorization is voluntary and General Physician PC will not refuse treatment based on my refusal to sign. I hereby authorize release of the requested medical records.

Signature: _____ **Date:** _____

Relationship to Patient other than self: _____

Witness: _____

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information and Sensitive Information

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

☐ My HIV-related information

☐ Both (non-HIV medical and HIV-related information)

☐ My non-HIV medical information **

☐ Any other sensitive information (ex: depression, anxiety etc.)

Name and address of facility/person disclosing HIV-related and/or medical information:

_____

_____ _____

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

_____

Relationship to person whose information will be released: _____

Describe information to be released: _____

Reason for release of information: ☐ Transfer of care ☐ Continuity of care ☐ Other _____

Time Period During Which Release of Information is Authorized From: _____To: _____

Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any:

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):

All facilities/persons listed on pages 1, (2 and 3 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.

Signature _____Date _____

*Human Immunodeficiency Virus that causes AIDS

** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.