AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS PURSUANT TO 45 CFR (164.508 {HIPAA})

Patient Name _____ Social security # _____

Date of birth _____

To: Any physician, surgeon, dentist, hospital, rehabilitation/ convalescent/custodial facility, pharmacist, ambulance, nurse, other health care provider or insurance company.

I, _____, authorize _____
To disclose and release the following protected health information: any and all important admissions, all ER visits, out patient clinic notes, diagnostic testing, radiology films, consults, doctors orders, progress notes, treatment plans, admission records, discharge summaries, medical summaries, diagnoses and/or any writing of any kind.

I understand that is the person(s) and /or organizations(s) listed above as the recipients of my protected health information I am authorizing the release of may no longer be protected by the federal or state privacy standards and my health information may be disclosed without obtaining my authorization. I will hold harmless Hamburg Regional Gynecology against any liability in connection with the disclosure of protected health information as authorization herein. I understand I may inspect and arrange for photocopies of the information that will be disclosed as a result of the authorization. This authorization will remain in effect to carry out the purpose for which it is intended, but will not remain in effect for dates of medical service beyond the stated expiration date. If I refuse to sign this authorization, my medical records/ information will not be released.

_____
Expiration date of authorization
(Will default to one year form date signed if no expiration date is given)

Also please disclose and release the following protected health information (only checked below)

____ Drug and alcohol records ____ Communicable disease: HIV and AIDS records

____ Mental health records (not including Psychotherapy notes)

This protected Health information is disclosed for the following purposes: verifying, evaluating, negotiating, and or other pertinent legal uses, with respect to the patient's insurance claim.

You are authorized to release the above records, or copies thereof, to any representative of Hamburg Regional Gynecology at the following address: 4154 McKinley Parkway, Suite 1200, Blasdell, NY 14219, 716-649-6500 or other
_____.

I further agree that a photocopy of the facsimile copy of this Authorization shall be valid and effective just as the original.

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I understand that I have the right to 1) inspect or copy the individually identifiable health information to be disclosed; 2) refuse to sign the Authorization; 3) receive a copy of this Authorization upon request.

_____ _____

Signature of patient or representative Printed name of Patient

_____ _____

Date Description of representative

Rights:

Right to inspect or copy the information to be used or disclosed. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclose by the Authorization form.

Right to receive a copy of the Authorization: I understand that if I agree to sign this Authorization, which I am not required to do, I must be provided with a signed copy.

Right to refuse to sign the Authorization: I understand that I am under no obligation to sign this form and that the person(s) and or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to withdrawal this authorization: I understand written notification is necessary to cancel this authorization or to receive a copy of my withdrawal I may contact Hamburg Regional Gynecology. I am aware that my withdrawal will not be effective for use or disclosures made previous to my withdrawal.

Please send records to:

_____

_____

_____

Office use only

Date: _____#of pages copies:_____@.75/page _____

Pt notified of fee: _____Paid date: _____

Completed by: _____