Processed By/Date:_____
MR#:_____

Lifetime Health medical group

Health Information Management Department

I hereby request and authorize Lifetime Health Medical Group to Release Medical Information:

Patient Name: _____

DOB: _____ 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 minors signature is required.

Patient Home Address _____

Home Phone #: _____

SEND MY MEDICAL RECORDS TO: _____

_____

_____

What information should be released? _____
(e.g., Specify by date, department or problem)

Do your medical records contain information related to *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*?

____No, my medical records do not contain the identified sensitive information.

____Yes. (The ***patient*** must complete the appropriate *Authorization for Release of Information* on the reverse side.)

Purpose for release of medical information:

____ Transfer of Medical Care Effective Date: _____

Reason for Transfer: _____

____ Referral to Specialty Provider ____ Immunization Records

____ Disability ____ Workers Compensation/No Fault

____ Other: _____

I understand that I have the right to revoke this authorization, in writing, at any time. (Requests to revoke an authorization must be directed to the attention of the Lifetime Health Medical Group, Health Information Management Department.) I understand that the two exceptions to the right to revoke are: (1) where Lifetime Health Medical Group 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 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 Lifetime Health Medical Group 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: _____

05- /1-03

Authorization For Release of Sensitive Information By Lifetime Health Medical Group

I hereby give permission to Lifetime Health Medical Group.

To release _____,
(Describe Sensitive Information to be released)

for _____,
(Purpose of the disclosure)

from the medical record of… Patient Name: _____,

DOB: _____,

To: _____
(Recipient of Sensitive Information)

_____.
(Recipients address)

Signature: _____ Date: _____

Relationship to Patient: _____

Witness: _____

***This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate in 90 days.

Authorization For Release of Confidential HIV and Related Information

Confidential HIV Related Information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV. Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form. If you sign this form, HIV related information can be given to the people listed on this form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.
If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights at (212)961-8624 or the New York City Commission of Human Rights at (212)306-7500. These agencies are responsible for protecting your rights.

Name of person whose HIV Related Information will be released:
Name and address of person signing this form (if other than patient): Relationship to person whose HIV information will be released:
Name and address of person who will be given HIV Related Information:
Reason for release of HIV related information:
Time during which release is authorized: From: _____ To: _____

My questions about this form have been answered. I know that I can deny release of HIV Related Information, and that I can change my mind at any time.

Signature: _____ Date: _____

New York State approved form, March 1997; Revised by Lifetime Health, July 2009