ADIRONDACK HEALTH

2233 State Route 86
Saranac Lake, NY 12983

Authorization to Release Health Information

Patient name:	Date of birth:
Address:	
Phone #:	Dates of service:

Information Requested (check all that apply):

☐ Abstract of medical record	☐ Immunization records	☐ Operative report
☐ Discharge summary	☐ Lab reports	☐ Office visit date(s): _____
☐ ER record	☐ Radiology reports	Name of provider: _____
☐ History and physical/consult	☐ Radiology images/CD	☐ Other: _____

Sensitive Information to be Released (initial all that apply):

Information relating to **ALCOHOL/DRUG TREATMENT, MENTAL HEALTH TREATMENT, GENETIC TESTING,** and/or **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION** will not be shared unless I specifically give permission. By placing my initials below, I specifically authorize the release of such information to the person(s) indicated on this form.

	Alcohol or Drug Abuse/Treatment Information
	Mental Health Treatment Information
	Genetic Testing Information
	HIV/AIDS-Related Information

Purpose: ☐ Personal use ☐ Other

☐ Transferring care From: _____ To _____

Medium: ☐ Paper ☐ Disc ☐ Mail ☐ Pick up ☐ Secure email

Adirondack Health may charge a reasonable, cost-based fee for this based on the number of pages. There is no charge for records sent directly to your physician or for requests of 10 pages or fewer.

Release information to (please print):

Name:	
Address:	
Phone #:	Fax #:

I Understand That:

1. Except for the sensitive information listed above, information that is shared because of this authorization may be shared again by the recipient and is no longer protected by federal or state law.

2. If I am authorizing the release of HIV/AIDS-related, alcohol or drug abuse/treatment, or mental health treatment information, the recipient(s) is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization, unless permitted to do so under federal or state law. I also have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at 212-480-2493. A recipient may not use any alcohol or drug abuse/treatment records protected by 42 CFR Part 2 against me in any civil, criminal, administrative, or legislative proceedings by any federal, state, or local authority.

3. I have the right to revoke this authorization at any time and this must be done in writing. Such revocation will not apply to information that has already been released in response to this authorization or to requests from government agencies, health insurance companies, certain law enforcement officials, and others who are entitled to information without authorization under HIPAA, federal or state law. Any disclosure of information has the potential for unauthorized disclosure or re-disclosure.

4. Unless otherwise revoked, this authorization will expire in twelve (12) months or on _____ . Requests for records after this date require a new authorization.

5. Signing this authorization is voluntary. Adirondack Health may not condition treatment, payment, enrollment in health plans, or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.

All items on this form have been completed, my questions about this form have been answered, and I have been provided or offered a copy for this form if Adirondack Health asked me to complete it.

Requester's name (printed): _____

Requester's signature:

_____ _____

Signature of patient, parent, legal guardian or healthcare proxy Date

Relationship to patient: _____

Co-Signature of minor patients (ages 12-17)*: _____

**A minor's signature (ages 12-17) is required for the following records: HIV-related information, sexually related treatment, mental health care, or substance abuse diagnosis and treatment.*

Release of Information 518-897-2567 / Fax Number 518-897-4575 / Health Information Management Dept 518-897-2520