Full Circle WOMEN'S HEALTH

450 Mamaroneck Ave. Suite 414, Harrison, NY 10528 t 914.421.1515 f 914.421.1501

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____ Phone _____ Date of Birth _____

PATIENT ADDRESS: _____

City, State, Zip _____

I hereby authorize Full Circle Women's Health to release my medical information to:

Name: _____

Address: _____ Phone: _____

City, State, Zip _____ Fax: _____

__

Please specify which medical records you want released and/or dates of service: (indicate by initialing)

_____ Annual exam and pap smear
_____ Pregnancy/Prenatal
_____ All medical records
_____ Surgical records
_____ Sonograms and Labs – copies of actual lab reports

_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information
_____ Other: _____

_____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- I may revoke this authorization at any time by providing written notice to the practice.
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- The practice will not condition treatment or payment based on my signing this authorization.
- I am signing this authorization freely and under no pressure from any individual to do so.
- The information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law.
- I acknowledge that I have had an opportunity to review this authorization and understand the intent and use. My questions about the form have been answered to my satisfaction.
- This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, and CONFIDEN TIAL HIV RELATED INFORMATION and MENTAL HEALTH TREATMENT (except psychotherapy notes) only if I place my initials on the appropriate box above. I specifically authorize release of such information to the person(s) indicated.
- If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand I 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 or the New York City C ommission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
- I may inspect and/or receive a copy of the information authorized for release pursuant to this authorization.
- My medical records may contain genetic testing information including test results.

This authorization expires in 6 months from the date signed below.

✔ Patient Signature _____ Date _____

For a Minor: I hereby declare that I am the natural or adoptive parent or legal guardian of said minor and there is no court order restricting or prohibiting my access to such medical records.

✔ Signature of Patient's Representative _____ Relationship _____ Date _____