HIGHLAND MEDICAL

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ____________________

Street Address: __________________________________ City: ____________________

State: ______ Zip Code: ____________ Phone Number: ____________________________

I, ________________________, hereby authorize Highland Medical to release my medical information to:

Name: ___________________________________ Attn: _________________________

Street Address: ________________________ City: ____________________ State: ______

Phone Number: ________________________ Fax Number: _________________________

Check all that apply:

- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test result, radiology studies, films, referrals, consultes, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Billing Records
- ☐ Labs/Radiology only
- ☐ Other (Please Specify): ____
- ☐ Drug and/or Alcohol Treatment

Authorization to Discuss Health Information

- ☐ By initializing here ______, I authorize Dr. ____________________ to discuss my health information with: _________________________________.

Reason for Requested Use or Disclosure:

- ☐ Personal Use
- ☐ Legal
- ☐ Second Opinion
- ☐ Change in Healthcare Provider
- ☐ Other (Please Specify): ____

Highland Medical
160 North Midland Avenue
Nyack, NY 10960
HighlandMedicalPC.org

Highland Medical

To Be Read and Signed by Patient

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.

b. 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.

c. The practice will not condition treatment or payment based on my signing this authorization.

d. I am signing this authorization freely and under no pressure from any individual to do so.

e. Information disclosed under the authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.

g. This authorization may include disclosure of information relating to alcohol and drug abuse, and confidential HIV related information only if I place my initials on the appropriate box above.

h. If I am authorizing the release of HIV related, alcohol, or drug treatment information, the recipient is prohibited from disclosing such information without my authorization unless permitted to do so under federal and state law. I understand that 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 information, I may contact the New York State Division of Human Rights at (212)-480-2493 or the New York City Commission of Human Rights at (212)-306-7450. These agencies are responsible for protecting my rights.

______________________________ ______________
Patient or Legal Representative Signature **Date**

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