Quality. Accessible Healthcare.

North Medical, P.C.

NORTH MEDICAL CENTER
5100 W. Taft Road
Liverpool, NY 13088
315-452-2828

NORTHEAST MEDICAL CENTER
4100 Medical Center Drive
Fayetteville, NY 13066
315-637-7878

AUTHORIZATION

For the disclosure of Protected Health Information ("PHI")
Medical Record Release

I, _____, the undersigned, authorize the use and/or disclosure of my Protected Health Information ("PHI") as described below. This information form is voluntary; North Medical, P.C. will not condition my treatment by signing of this authorization form.

☐ Psychotherapy Notes: Check here if this authorization is for psychotherapy notes. If so, please disregard item 4 (below) as this authorization cannot be used for any other purpose if Psychotherapy Notes is checked.

☐ HIV-related Information: Check here if this authorization is for HIV-related information. If so, in addition to completing this form, please complete the attached New York State Department of Health mandated *Authorization of Release of Confidential HIV-Related Information.*

1. Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No. _____ Social Security: _____

2. Person/Facility Authorized to RELEASE PHI (copies of medical records)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

3. Person/Facility Authorized to RECEIVE PHI (copies of medical records)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

4. Description of PHI to be Disclosed (entire medical record, lab/xray reports; specific dates of services, etc.)

_____

_____

_____

5. Reason for Disclosure: Please indicate the reason for the disclosure of the above stated PHI.

_____

6. **Expiration: This authorization will expire**

- ☐ Upon completion of the requested disclosure
- ☐ Six months from date of this authorization form
- ☐ On _____/_____/_____ (MM/DD/YYYY)
- ☐ One year from the date of this authorization form

I understand that this authorization shall become effective immediately, and unless otherwise revoked be me in writing shall expire as indicated above. I further understand that when my PHI is disclosed pursuant to this authorization, it may be subject to redisclosure by the persons authorized to receive my PHI.

Dated: _____ 20_____ _____

Signature of Patient or Personal Representative

_____ _____

Printed Name of Patient or Personal Representative Description of Personal Representative's Authority

If you are requesting your previous provider send your medical records to NMPC, please send this form to the provider requesting they send your records to:

North Medical, P.C.
Medical Records Department
5100 West Taft Road, Suite 1W
Liverpool, NY 13088
Tel: 315-452-2837
Fax: 315-452-2512

If you are requesting NMPC send your record to a new provider, please complete and return to:

North Medical, P.C.
Medical Records Department
5100 West Taft Road, Suite 1W
Liverpool, NY 13088
Tel: 315-452-2837
Fax: 315-452-2512

Thank You.