Jefferson Family Medicine
924 Jefferson Avenue ▪ Rochester, NY 14611
P: 585-463-3870 F: 585-463-3873

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name_____
(Last) (First) (MI)

DOB: _____ SSN (if applicable)_____ MR#_____

Extent or nature of disclosure is limited to: CHECK all that apply.

□ Discharge Summary	■ History & Physical	■ Social Assessment
■Psycho-Social Assessment	■ Psychiatric Evaluation	■ Progress Notes
□ Physician Orders	□ Dates in program	□ Treatment Plan
■ HIV Testing and Treatment	■ Chemical Dependency	■ Mental Health/Behavioral Health

■ Other: All records including immunization records

Specific purpose of need for disclosure is: Continuity of care
I give permission for:

Agency/Person: _____
Address: _____
Phone:_____ Fax:_____
(see attached list for more providers if necessary)
TO DISCLOSE information to:

Agency/Person: __**Jefferson Family Medicine, P.C.** _____
Address: ____**924 Jefferson Avenue, Rochester, NY 14611**_____

The information you designate for disclosure will be disclosed from records protected by Federal and State Confidentiality rules including HIPAA, 42 CFR part 2 for substance abuse, and NYS Public Health Laws specific to HIV. The Federal rules prohibit the recipient of the information from making any further disclosure of this information, unless further disclosure is expressly permitted by your written authorization, or as permitted by state and federal regulations. A general authorization for the disclosure of other information is NOT sufficient for this purpose.

I, the undersigned, have read the above and authorize staff of the disclosing facility to disclose such information as herein contained. I understand that I may revoke or cancel this authorization at any time. Withdrawal of the authorization does not affect any information disclosed before providing a written notice of such a withdrawal of the authorization. This authorization will remain in effect no longer than one year in order to carry out the purpose for which my permission was given. I understand that the program releasing these records is free from all legal liabilities that may arise from this act. I understand that I have the right to limit the information that is to be disclosed and who can see this information. A photocopy of this authorization is as valid as the original.

I understand that generally Jefferson Family Medicine may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form.

Expiration Date: One year from signature date

Patient or Representative Signature _____ Date_____
Representative's relationship to the patient _____

Facility Witness Signature_____ Date_____

□ I Cancel my permission to disclose the information described on this form.
Patient Signature_____ Date
_____
Facility Witness Signature_____ Date_____

Jefferson Family Medicine
924 Jefferson Avenue ▪ Rochester, NY 14611
P: 585-463-3870 F: 585-463-3873

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name_____
(Last) (First) (MI)

DOB: _____ SSN (if applicable)_____ MR#_____

Please copy this page as needed to include all participating providers

Agency/Person: _____
Address: _____
Phone:_____ Fax:_____

Agency/Person: _____
Address: _____
Phone:_____ Fax:_____

Agency/Person: _____
Address: _____
Phone:_____ Fax:_____

Agency/Person: _____
Address: _____
Phone:_____ Fax:_____

Agency/Person: _____
Address: _____
Phone:_____ Fax:_____

Agency/Person: _____
Address: _____
Phone:_____ Fax:_____

Patient or Representative Signature _____
Date_____