HEALTH INFORMATION USE AND DISCLOSURE – NEPHROLOGY ASSOCIATES OF SYRACUSE, PC

PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF BIRTH

By signing this form, I authorize Nephrology Associates of Syracuse to disclose the health information described below to:

Person/Company _____

Address _____

City _____ State _____ Zip _____

SELECT FORMAT: I prefer my records to be in (select one)

Paper format, I agree to pay $0.75 per page _____ CD in PDF format /$5 per CD _____

CD of radiology image / $5 per CD _____ Delivery – Select: US Mail or Federal Express

(Shipping charges apply); or you may pick up

SELECT THE RECORDS YOU ARE REQUESTING:

All health information _____

Health information for date (s) _____ through _____

Other (describe specifically) _____

REASON FOR AUTHORIZATION: at my request

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied. I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Privacy Officer at Nephrology Associates of Syracuse.

1. This authorization may include disclosure of information relating to Alcohol and Drug Abuse, Mental Health Treatment, except psychotherapy notes, and Confidential HIV Related Information, unless I check the appropriate box(es) below. Otherwise, in the event the health information described below, includes any of these types of information, and I initial the line on the box, I specifically authorize release of such information to the person(s) or entity indicated.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or 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-related information, I may contact the New York State Division of Human Rights at (888) 392-3644 or TDD/TTY (718) 741-8300

Include: (Indicate by Initialing)

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

_____ _____

Patient Signature/Legally Authorized Representative Date

_____ _____

Printed Name Relationship to patient

NOTE: This document must be made part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative. Expiration: Release form expires 6 months from date signed unless otherwise written here_____.