Community Health Center of the North Country

AUTHORIZATION FOR RELEASE OF RECORDS
4 Commerce Lane, Canton, NY 13617
Phone (315) 379-8100, FAX: (315) 386-1410

Name:_____ **DOB:**_____

This authorization is written permission for the Community Health Center of the North Country to use, disclose or obtain my protected health information as directed below:

_____Use _____Disclose to _____Obtain from

Name of organization/person: _____
Address:_____
Phone:_____ Fax: _____

Specific information to be released:

- o Entire Record (including patient histories, progress notes, test results, radiology, referrals, and consults);

Or only the following:

- o History and Physical
- o Progress Notes
- o Lab Results
- o X-Ray results
- o Other Test results: _____
- o Other information:_____

Include: □ Mental Health Information □ HIV-Related Information

Circle all that apply:

Primary Care Dental Optometry Foot Care Physical Therapy Mental Health

The protected health information will be used, disclosed or obtained for the following purposes:

_____

_____

_____

The authorization will expire in ninety (90) days or will be in effect until_____, or until _____.
Date Event

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notice to CHC of the North Country. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted by state/federal law
- Refuse to sign this authorization and it will not affect my treatment, payment, or eligibility for benefits.

_____ _____
Signature of Person or Personal Representative Date

_____
Printed Name of Person or Personal Representative

_____
Description of Personal Representative's Authority

Please send the above requested information to:

Community Health Center of the North Country
4 Commerce Lane, Canton, NY 13617
Attn: _____

This document meets requirements under Federal HIPAA Privacy regulations

Date Created:4/03
Review/Revision Dates: 05/09, 07/10, 10/12, 2/13, 6/13, 12/13, 3/14Σ MMKMC