Slocum-Dickson
Medical Group P.L.L.C.
1729 Burrstone Road, New Hartford, NY 13413 (315) 798-1500

PATIENT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

1._____
Patient Name Date of Birth Phone Number

_____
Address City, State Zip

Reason for Use/Disclosure of Information:

☐ Patient Access ☐ Continuity of Care/Medical Treatment: **Upcoming Appointment Date:**_____ ☐ Disability

☐ Insurance ☐ Legal Reasons ☐ Transfer of Care ☐ Other: Explain _____

2. Name and Address of Physician/Facility Releasing Information:

_____
_____
_____
_____

3. Name and Address of Physician/Facility/Person Receiving Information:

_____
_____
_____
_____

4. Specify information to be released (include provider name/s, dates of service/s, documentation needed):

_____

5. **If applicable**, I authorize the release of the following documentation. If authorizing the release of this information please check and initial:

☐ _____Substance Abuse Records (Initial) ☐ _____Psychiatric Records (Initial) ☐ _____HIV (requires a separate signed NYS release form) (Initial)

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING SUBSTANCE USE:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder.

I understand that Slocum-Dickson Medical Group will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment. I understand that, if requested, Slocum-Dickson Medical Group will provide me with a copy of this authorization form after I sign it. Per New York State statute, this facility shall charge $.75 per page for copies. If a person is unable to afford such a payment, and shows proof of inability to pay, the fee will be waived.

6. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (please check one)

☐ one year ☐ at the end of the patient/physician relationship ☐ other:_____

I understand that I have a right to revoke this authorization at any time. In order to revoke this authorization, I must do so in writing, and present my written revocation to the Slocum-Dickson Medical Group Health Information Services Department, Attn: Release of Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Signature of Patient or Patient's Representative/Relationship to Patient Date

_____ _____
Signature of Witness Date

TO BE COMPLETED BY SLOCUM-DICKSON EMPLOYEES ONLY

For Releases:
Validation of Requestor's Identity _____
(Please note form of ID presented)
Complete by:_____ Date:_____

For Requests:
Request Sent By____
Date:_____Via: ☐ Fax ☐ Mail
Department:_____

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