Finger Lakes COMMUNITY HEALTH Taking the time to care.	**Patient Name:**
	Date of Birth:
	Address:
	City: **State:** **Zip Code:**

Finger Lakes Community Health Release of Information Form

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

I hereby permit the use or disclosure of the information as shown on page 2 to the Person/ Organization/ Facility/ Program(s) identified on page 2. I understand that:

1. Only the information described in this form (as shown on page 2) may be used and/or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and all federal and state regulations as outlined below.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be redisclosed and would no longer be protected by HIPAA. However, mental health testing and/or treatment information will still be protected under the NYS Mental Hygiene law, which prohibits this information from being redisclosed by anyone who receives it unless the redisclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
4. I understand that my substance use disorder records as applicable are protected under federal law, including the federal regulations governing confidentiality of substance use disorder patient records, 42.C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided by regulations.
5. I understand that my HIV status (as applicable) including testing, exposure to, infections or related illnesses, or treatment for HIV/AIDs is protected under Article 27-F of New York State Public Health law and that any release of said information must be accompanied by my authorization. For more information about HIV confidentiality call the New York State Department of HIV Confidentiality Hotline at 1-800-962-5065.
6. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing and provided to Finger Lakes Community Health. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
7. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
8. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524, 42 C.F.R. Part 2, and NYS Mental Hygiene Law §33.16.
9. For more information regarding federal privacy protection, I can call the office for Civil Rights at 1-800-368-1019. I also can contact the NYS Division of Human Rights at 1-888-392-3644.

(Form continued on Page 2)

(Continued from page 1)

Patient Name: _____ Date of Birth: _____

This information is requested by the patient or their authorized representative.

The purpose of disclosure is to establish Primary Care services with a Finger Lakes Community Health Provider

The information is to be released to Finger Lakes Community Health

Finger Lakes Community Health, 601 B West Washington Street, Geneva, NY 14456

Email: healthinformation@flchealth.org Fax: 315-781-8444 Phone: 315-781-8448 (Option 3)

Contact Information For the Medical Provider who FLCH will request records from:

Name:					
Address:					
City:		**State:**		**Zip Code:**	
Phone:		**Fax**			
Email:					

Release Records via (select one): ☐ **Mail** ☐ **Fax** ☐ **eMail**

Date Range Being requested: Last Seven (7) years

Specific information to be released:

☒ Discharge Summary	☒ Pathology Reports	☐ Tooth Chart
☒ Laboratory Results	☒ Consult Reports	☒ X-Ray Reports
☒ History and Physical	☒ Immunization Records	☐ X-Rays (dental)
☒ Progress Notes	☐ Emergency Room Notes	☐ itemized Bills/Payments

☐ Other (please describe): _____

Special Authorizations (patient and or patient representative initials must be present in order to release specified information, please review informed consent section on page 1 for information regarding these special authorizations):

_____ I authorize the release of substance use disorder records in accordance with federal regulations regarding the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability act of 1996, 45 C.F.R. Parts 160 and 164 as stated in the informed consent on page 1 of this release form.

_____ I authorize the release of my evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation neuropsychological information in accordance with NYS Mental Hygiene Law 33.13 in accordance with the informed consent on page 1 of this release form.

_____ I authorize the release of my testing, diagnosis or treatment for HIV/AIDS in accordance with HIPAA regulations and Article 27-F of New York State Public Health Law as stipulated in the informed consent on page 1 of this release form.

Name of Person Requesting the Records: _____

Relationship of the person requesting records to the patient: _____

Authorized Signature: _____ Date_____

Received By: _____ Date: _____

Note: If the patient is an adult and the requestor is anyone else, the requester must submit proof of legal authority to request the records. If the patient is a minor and the requester is anyone other than the parents, the person must provide documentation of their legal authority to request records.