AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize _____
   Medical provider's name, phone number, fax number

   to release the health information of the individual named below:

   Patient Name: _____ SSN#: _____

   Address: _____

   Phone #: _____ Date of Birth: _____

2. I authorize the information to be disclosed to and used by the following organization:

   Caring Family Medicine PLLC
   225 Middle Country Rd, Suite 3
   Middle Island, NY 11953
   Phone: 631-775-8850 Fax: 631-775-8852

   For the purpose of: _____

3. The type and amount of information to be disclosed is as circled below, dates specified as appropriate:

   Entire Medical Record
   Most recent 1, 3, 5 years of Record
   Immunizations
   HIV/AIDS information, from _____to _____
   Laboratory results, from_____to_____
   X-ray results, from _____to _____
   Genetic testing, from_____to _____
   Entire Medical Record for Diagnosis of _____, from _____to _____
   Other _____

   **I will pick up __ Mail to: SFP as above Fax to: SFP as above

4. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
5. I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
6. I understand that the authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization, SFP cannot condition treatment, payment, enrollment in a health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
7. I accept full financial responsibility for copying fees. Per the New York State Department Health, the fee for copying requested documents is $0.75 per page. Shipping will also be charged. There is no charge for records sent to another health care provider.

X_____ X_____
Signature of Patient or Authorized Personal Representative Date

_____
Personal Representative's Name and Relationship to patient