PERRELLA HEALTH CENTER
HARTWICK COLLEGE
ONEONTA, NEW YORK 13820
Phone: 607-431-4120 Fax: 607-431-4124

AUTHORIZATION FOR THE DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

PATIENT IDENTIFICATION: PLEASE PRINT

Patient Name: (please print) _____ DOB:_____

Address: _____ Phone #:_____

_____

Dates/ Name of treatment/test/report: _____

_____

DISCLOSURE INFORMATION FROM AND TO:
Name: _____
Phone#: _____ Fax #:_____
Address:_____
_____

DISCLOSURE INFORMATION TO AND FROM:
Name: _____
Phone #: _____ Fax#: _____
Address: _____
_____

Notice to Patient:

I authorize the above named provider to disclose information from my medical records, test results and other information regarding the patient care concerning the above named patient for the period specified. This authorization includes confidential information such as:

1. Psychological or psychiatric impairment
2. Drug use and / or alcohol abuse
3. Acquired Immunodeficiency Syndrome (AIDS), and / or
4. Test for infection with Human Immunodeficiency Virus (HIV)

I understand this authorization may be revoked at patient's request; otherwise it will automatically expire twelve (12) months from the date signed below.

To receiving Agency: These records may not be disclosed without the patients consent.

_____ _____
Signature of patient or authorized legal guardian Date

_____ _____
Relationship to patient, if signed by authorized representative Date

_____ _____
Witness Date

For Office Use Only

Date Mailed/Faxed: _____ Date of Pick-Up: _____

By Whom (Please Initial): _____ By Whom (Please Initial): _____