CAREMOUNT MEDICAL
caremountmedical.com

Email to MedRec1@caremount.com or
Fax # 914-242-1393

Highlighted fields must be completed

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name (Last Name, First Name)			**Date of Birth**
Street Address	**City**	**State**	**Zip Code**

I, or my authorized representative, request that health information regarding my care and treatment is released as set forth on this form.

From: CareMount Medical P.C.	**To:** _____
Provider Name and Address: _____	**Name and Address:** _____
_____	_____
Telephone Number: _____	**Telephone Number:** _____
	Fax Number (for providers only): _____

Specific information to be released:

- ☐ **Entire Medical Record from (insert date)**_____**to (insert date)** _____
- ☐**Specific Portions of the Medical Record as follows:** _____
- ☐ **Other**: _____

☐ **Check if granting authorization to discuss health information**	**Include: (*Indicate by Initialing)*** _____ **HIV-Related Information*** _____ **Genetic Testing (inherited)**
Reason for release of information: ☐ **At request of individual** ☐ **Other:**	**Date or event on which this authorization will expire:** ***This authorization will remain in full force and effect until I revoke such authorization which I have agreed to do in writing.*** _____**(*Indicate by initialing*)**

In accordance with applicable law, I understand that:

This authorization may include disclosure of information relating to **CONFIDENTIAL HIV* RELATED INFORMATION** and/or **GENETIC TESTING** only if I place my initials on the appropriate line above. In the event the health information described above includes any of these types of information, and I initial the line on the box above, I specifically authorize release of such information to the person(s) indicated above.

If I am authorizing the release of HIV-related or genetic testing information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal and state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.

I understand that there is a fee of up to $0.75/ page for copies of paper records that are not being sent to another health care provider based on NYS Public Health Law 18.

If not the patient, name of person signing form:	**Authority to sign on behalf of patient:**
_____ **Signature of patient or representative authorized by law**	**Date:** _____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**