

**Authorization for Release of Medical Information**

Please complete all required sections legibly in blue or black ink in order for us to process this request. Form must be signed by patient or legal guardian (if minor), or power of attorney with attached documentation. Incomplete or inaccurate forms will not be accepted.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SS#: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I authorize **Victor Health Associates** to release the information specified below, to the following:

Name of Provider/Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PURPOSE FOR THIS REQUEST:** (Check one) \_\_\_\_ Transfer of Care \_\_\_\_ Health Care \_\_\_\_ Other (specify): \_\_\_\_\_

**INFORMATION TO BE DISCLOSED** Please check #1 or #2

- 1) Complete Record - Please answer all by checking Yes or No to the right of each question**
  - including alcohol/drug related information \_\_\_\_\_ Yes \_\_\_\_\_ No
  - including information related to treatment for sexually transmitted diseases \_\_\_\_\_ Yes \_\_\_\_\_ No
  - including mental health related information, such as depression, anxiety \_\_\_\_\_ Yes \_\_\_\_\_ No

**2) Other** \_\_\_\_\_

**AUTHORIZATION VALID FOR:** (Check One)

- This request only.
- One year from the date of this authorization **OR** through \_\_\_\_\_ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

**I understand that**

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form., except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.
- Release of HIV-related information requires additional authorization.

I further realize that under New York State Health Law, Section 17, charging for copies of medical records is permissible, and that the office will charge \$0.75 per page for printed records.

\_\_\_\_\_  
Signature of Patient / Legal Representative Date

Print Name and Relationship to Patient (if requester is not the patient): \_\_\_\_\_