**AUTHORIZATION TO RELEASE MEDICAL RECORDS TO FAMILY MEDICINE OF MALTA**

NAME OF PAITENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_\_\_\_\_\_\_\_\_ S.S.N\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF PHYSICAN RELEASING RECORDS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the release of the information found in the medical records for the above-named patient including information pertaining to substance abuse (drugs/alcohol), HIV and psychiatric and/or mental health records.

Please send this information to:

Family Medicine of Malta FAX TO

2299 Route 9 OR 518-899-5343

Mechanicville NY 12118 ATTN: MEDICAL RECORDS

518-899-5390

The duration of this authorization in one year unless otherwise specified by the above-named patient, parent (if patient in minor) or legal guardian and may be revoked at any time by notification in the form of written letter except to the extent that action has already been taken based on my consent

Family Medicine of Malta may use or disclose protected health information (PHI) to a third party under any authorization obtained from individual remitting the sue of disclosure of PHI.

I understand that the disclosure of this health information is voluntary. I do not need to sign this form in order to ensure treatment. I also understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and if some may not be subject to Federal or State Law protecting its confidentiality.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_