Victor Health Associates

Specialists in Pediatrics and Internal Medicine

6532 Anthony Drive, Suite A
Victor, New York 14564
Telephone: (585) 924-2100
Fax: (585) 398-1217

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. **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 obtain information from:

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 #1or #2 or #3*

☐ **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.

☐ **3) No previous physician medical records to obtain.** ***Explain:*** ____________________

____

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 NY State Health Law, Section 17, charging for copies of medical records is permissible, and that the office will charge $0.75 per page.

____ ______________

Signature of Patient / Legal Representative Date

Print Name and Relationship to Patient (If requester is not the patient): ________________________________