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. 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 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*

☐ **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. Please verify cost or electronic option with the office to receive this form directly.

_____ _____

Signature of Patient / Legal Representative Date

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