Pembroke Family Medicine **www.pembrokefamilymed.com**

860 Main Road
Corfu, NY 14036

319 West Main
Batavia, NY 14020

3399 Buffalo Street
Alexander, NY 14005

Mary Obear MD, PhD ~ Ashton Raduns ANP
Lily Snyder MD ~ Lisa Feitshans ANP, PNP ~ Larraine Wende FNP
Matthew Fernaays MD ~ Shelly Bish FNP ~ Christina Sobczak PNP

Ph: (585)599-6446 Fx: (585)599-3166

Authorization for Release of Protected Healthcare Information

Name of Patient _____

Date Of Birth _____ SS# _____

Address _____

City _____ State _____ Zip Code _____

I hereby request and authorize Pembroke Family Medicine to **release** protected healthcare information of the patient named above **to**:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Specific information to be released:

☐ Entire Medical Record, including patient histories, office notes, test results, radiology studies, films, consults, and records sent to you by other health care providers and facilities.

Include: **(Indicate by Initialing)**

_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV Related Information

☐ Medical Records from (insert date) _____ to (insert date) _____

☐ Other: _____

_____

Reason for release of information:

☐ Transferring Care ☐ Other: _____

1. I understand that this authorization will expire one year after it is signed. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Pembroke Family Medicine at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I have the right to request for a photocopy of this form after I sign it.
7. Definition: Sexually Transmitted Diseases (STD) as defined by law, RCW70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL,chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Syndrome) AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient _____ Date _____

OR

Parent/Legal Guardian/Authorized Person _____ Date _____