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

in order for us to process this request, complete all sections in blue or black ink. **Incomplete or inaccurate forms will not be accepted**.

Patient Name:_______________________________ Date of Birth: ______________

Address: ____

City: ____________________ State:__________ Zip: ____________________

Phone: (_____) _________-________________ SS #: ________________

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 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**

Please Check #1 or #2 or #3:

☐ **1) Pertinent Records**

☐ **2) Other** ____

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

____

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 NYS Health Law, Sec.17, charging for copies of medical records is permissible, and that the office will charge $0.75/page.

____

Signature of Patient / Legal Representative Date

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