Regional Primary Care Network

PERMISSION TO SHARE PATIENT INFORMATION

☐ **Livingston CHC**
1 Murray Hill Drive
Building 1, Room 140
Mt. Morris, NY 14510
585-243-7840
585-554-3342 (HIPAA fax)

☐ **Rushville CHC**
2 Rubin Drive
Rushville, NY 14544
585-554-4400
315-279-6705
585-554-3342 (HIPAA fax)

☐ **Utica CHC**
1651 Oneida Street
Utica, NY 13501
315-793-7600
315-792-0079 (HIPAA fax)

☐ **Wayne CHC**
1519 Nye Road
Lyons, NY 14489
315-871-3178
585-554-3342 (HIPAA fax)

☐ **Valley FHC**
55 Central Plaza
Suite B
Ilion, NY 13357
315-444-1900
315-792-0079 (HIPAA fax)

Patient Name: _____Date of Birth: ____-____-_____

Address: _____

Phone Number: _____-_____-_____

I authorize _____Community Health Center to share information about my healthcare to the following:

_____ _____
Name Relationship

For the purpose of sharing the following information (check all that apply):
___Appointments
___Test Results
___Medications, including picking up prescriptions
___Care Planning
___Financial information
___Other: _____

I authorize RPCN staff to communicate information about me and my care using the following methods (select all that apply).

___Telephone/Voicemail ___Email ___Text Message ___Verbally

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment.

___Check here to indicate that you request **NO ACCESS** at this time

_____ ____-____-_____
Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship to patient: _____

_____ ____-____-_____
Witness Date

12/2016

This form will be renewed annually to update patient preferences for sharing information