Regional Primary Care Network

Medical Record # _____

☐ **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
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)

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

Patient Name: _____**Date of Birth:** _____

Address: _____

Phone Number: _____

I authorize _____Community Health Center:

☐ TO RELEASE the above named individual's health information to:	☐ TO OBTAIN the above named individual's health information from:
Name:	
Address:	
City/State/Zip Code:	
(Area Code) Phone:	(Area Code) Fax Number:

1. Description of information that may be disclosed (check off the appropriate items):
___History & Physical From: _____To: _____ (*enter dates of service)*
___Laboratory Results From: _____To: _____ (*enter dates of service)*
___Dental X-Ray Results From: _____To: _____ (*enter dates of service)*
___Entire Medical/Dental Record ___Entire Medical Record ___Entire Dental Record
___Shot Record ___Prescriptions
___Other (please describe) _____

*Specific authorization is required to release the following documentation. If authorizing release, please check and initial:
____Substance Abuse Records ___ *initial*
____Psychiatric, Mental Health, or Behavioral Health Records ___ *initial*

****HIV requires separate NYS Release Form****

2. The information will be used/disclosed for the following purposes:
___Disability ___Insurance/Payment of Bills ___Legal
___Referral /Care Coordination ___Transfer of Care
If Transferring Care to another provider, please provide reason:
___Moved out of Area
___Changed Provider(s)
___RPCN does not take my insurance
___Location Inconvenient
___Transportation Issues
___Dissatisfied
___Other (explain) _____

SIGNATURE IS REQUIRED ON P.2 FOR THIS REQUEST TO BE VALID

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3. I understand that if the person or entity receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information authorized for disclosure in item #1 above could be re-disclosed.

4. I understand that by authorizing Regional Primary Care Network to use/disclose the information, that they may receive compensation for reasonable expenses incurred for making photocopies of my records.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or request a copy of any information disclosed under this authorization, per Regional Primary Care Network's "Request for Access to Medical Records" policy.

6. I understand that I may revoke this authorization in writing at any time by contacting the Health Information Management Department at _____Community Health Center, except to the extent that action has been taken in reliance on this authorization.

This authorization expires on: _____ (insert date or event), or within one (1) year of the date of authorization, whichever is less.

_____ _____
Signature of Patient or Legal Representative Date

_____
If signed by Legal Representative, relationship to patient