OAK ORCHARD COMMUNITY HEALTH CENTER

☐ 300 West Avenue Brockport, NY 14420
Fax #: (585) 637-2375

☐ 301 West Avenue Albion, NY 14411
Fax # (585) 589-0872

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize Dr. ________________________ of the ***Oak Orchard Community Health Center*** to:

Please write the complete address below:

Please check appropriate box below:

☐ **SEND** my records to:
☐ **OBTAIN** my records from:
☐ **PICK UP** my own records
☐ **SHARE** my information **verbally** with:

____

____

________________________ Zip Code: _________________

☐ **I am transferring** care to this doctor. (Please complete the survey on the reverse side if you are transferring out of Oak Orchard Community Health Center.)

☐ **I am not transferring.** The purpose of this request is**:** ______________________________

PLEASE SEND: *I understand that Oak Orchard Community Health Center charges up to $0.75 cents per page for copying my designated record* (except for records being sent to a referring specialist.)

☐ All RECORDS: (**except**, as authorized by law, release of HIV/AIDS or alcohol/drug or mental health-related information which will require a specific record release form.)

☐ SELECTED INFO: Please specify: (ex: send past 5 years **or** information related to ……. **or** send lab results: ______________________________________

THIS RELEASE APPLIES TO: (**Please note**: Patients 18 years or older ***must*** sign individually.)

Patient(s) Name:	DOB:	Relationship to Signer:	Chart #:
1)			
2)			
3)			
4)			

AUTHORIZATION VALID FOR: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: __________________________. If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date of signing. (**Example:** "When acted upon" or "When I am no longer receiving services".)

I understand that:

- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form. I understand that the cancellation will not apply to information that has already been released in response to this 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 redisclosed.
- If I wish, I can receive a copy of this authorization form, after signing.

Signature: ____ Date: ____________________
(Patient or Personal Representative)

Patient's Address: ____ Zip Code: ___________

Witness: ____ Date: ________________