PERRELLA HEALTH CENTER
HARTWICK COLLEGE
ONEONTA, NEW YORK 13820
Phone: 607-431-4120 Fax: 607-431-4124

AUTHORIZATION FOR THE DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

PATIENT IDENTIFICATION: PLEASE PRINT

Patient Name: (please print) ____ DOB:_________________________

Address: ____ Phone #:________________________

____

Dates/ Name of treatment/test/report: ____

____

DISCLOSURE INFORMATION FROM AND TO:
Name: ____
Phone#: ____ Fax #:______________________________
Address:____
____

DISCLOSURE INFORMATION TO AND FROM:
Name: ____
Phone #: ____ Fax#: ___________________________________
Address: ____
____

Notice to Patient:

I authorize the above named provider to disclose information from my medical records, test results and other information regarding the patient care concerning the above named patient for the period specified. This authorization includes confidential information such as:

1. Psychological or psychiatric impairment
2. Drug use and / or alcohol abuse
3. Acquired Immunodeficiency Syndrome (AIDS), and / or
4. Test for infection with Human Immunodeficiency Virus (HIV)

I understand this authorization may be revoked at patient’s request; otherwise it will automatically expire twelve (12) months from the date signed below.

To receiving Agency: These records may not be disclosed without the patients consent.

____ ___________________________
Signature of patient or authorized legal guardian Date

____ ___________________________
Relationship to patient, if signed by authorized representative Date

____ ___________________________
Witness Date

For Office Use Only

Date Mailed/Faxed: ____ Date of Pick-Up: ___________________

By Whom (Please Initial): _______________________________________ By Whom (Please Initial): ___________