

Margot L. Fass, MD 527 Linden Street Rochester NY 14620 585-256-1105

**AUTHORIZATION FOR PROTECTED HEALTH INFORMATION**

I hereby authorize Dr. Fass to receive and/or disclose protected health information re: (patient name)

DOB: \_\_\_\_\_

From/To: (name & address of recipient) \_\_\_\_\_

For the purpose of coordination of care, diagnostic assessment, follow-up, referral, or other

\_\_\_\_\_

I understand that:

- 1) THIS AUTHORIZATION IS VOLUNTARY & I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE;
- 2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state & federal law. See 45 CFR/164.524)
- 3) I may revoke this authorization at any time by notifying Dr. Fass in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon
- 4) If the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, the released information may no longer be protected by Federal Privacy Regulations
- 5) If I am authorizing the release of drug or alcohol information, the recipient is prohibited from re-disclosing any drug or alcohol information without my authorization unless permitted to do so under federal or state law.

Type of Information to Be Disclosed:

- |   |   |
|---|---|
| <input type="checkbox"/> Entire Medical Record        | <input type="checkbox"/> Most recent 5-year History             |
| <input type="checkbox"/> Office Chart Notes           | <input type="checkbox"/> History & Physical Exam                |
| <input type="checkbox"/> Billing Statements           | <input type="checkbox"/> Emergency & Urgent Care Records        |
| <input type="checkbox"/> Laboratory Reports           | <input type="checkbox"/> Medical Records for Continuity of Care |
| <input type="checkbox"/> Pathology Reports            | <input type="checkbox"/> Diagnostic Imaging Reports             |
| <input type="checkbox"/> Consultation                 | <input type="checkbox"/> Radiology Reports                      |
| <input type="checkbox"/> Discharge Summary            | <input type="checkbox"/> Operative Reports                      |
| <input type="checkbox"/> Verbal/Written Communication |   |

In addition, I authorize that this will include health information relating to (check if applicable):

- |  |   |
|--|---|
| <input type="checkbox"/> Genetic Testing | <input type="checkbox"/> Drug/Alcohol Abuse |
|--|---|

Please describe kind and amount of drug/alcohol information to be disclosed:

Routine Screening Questions  Other \_\_\_\_\_

**Expiration:** This authorization will be valid ongoing throughout treatment.

\_\_\_\_\_  
(Patient's Signature)

\_\_\_\_\_  
(Parent or Guardian Signature)

\_\_\_\_\_  
(Witness; Signature)

\_\_\_\_\_  
(Date)