THE HILL OB-GYN ASSOCIATES
1000 East Genesee Street
Suite 500
Syracuse, NY 13210
Ph. (315) 471-2713 Fax (315) 471-1012
Jerry Caporaso Jr., MD

Authorization for Disclosure/Release of Health Information

Patient's Name: _____ DOB: _____

Covering Period: _____

I authorize **The Hill OB-GYN Associates, P.C.** to release my medical information, including but not limited to, information on HIV and/or communicable diseases, also including any or all other laboratory/pathology results and Radiological tests. Any psychiatric conditions, or alcohol & drug abuse information.

Below is the name of a family member or other individual this information may be released to, via phone conversation or other means necessary.

1)_____ 2)_____

May we leave appointment reminders on (**please check all that apply**) ☐ E–mails ☐ home answering machine, ☐ cell phone, or ☐ with another person at your residence
May we leave medical information on ☐ home answering machine, ☐ cell phone, or ☐ with another person at your residence if listed
Requests for a minor (under age 18) should be signed by a parent having legal custody or by the legal guardian, except in situations protecting the minor's privacy as stated by NY State Health Code regulations.

Requests for records of a deceased patient require proof of the requestor's authority as Executer or Administrator of the Estate.

A Spouse's signature is accepted only in an emergency or if the spouse has power of Attorney or is the Health care proxy and can submit proof of such.

I understand that if the person or entity that receives the information is not a health care provider covered by federal Privacy regulations, the information described above may be re-discloses and no longer protected by these regulations.

I understand I have the right to revoke this authorization at any time with written request. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or discloses my protected health information, have acted on reliance upon this authorization. **The Hill OB-GYN Associates, P.C.,** its employees, physicians and officers are released of any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herin.

Patient's Signature: _____ Date: _____