The Hill OB-GYN Associates, PC

Patent Authorization for Release of Medical Information

This form authorizes the disclosure of protected health information, which may include confidential HIV-related information.

Send Medical Records To/from:

Physician_____ Address_____

City_____State_____Zip_____

Phone_____Fax_____

Patient Name_____Address_____

City_____State_____Zip_____

Phone_____Date of Birth_____

Information to be disclosed:

Please send last TWO years of office visits, lab work and pathology. Please include all surgeries.

Include **(Indicate by Initialing)**

_____HIV Related _____Behavioral Health _____Treatment for Alcohol

****This authorization may include disclosure of HIV, alcohol and/or drug abuse, and mental health treatment ONLY if your initials are placed on the lines above. In the event the health information described above includes these types of information, and I initial the line above, I specifically authorize release of such information to the person(s) indicated above.**

___Other (please specify) _____

Specific Date Range: From _____ to _____

Reason for Disclosure: ___Primary Care/Specialist ____Patient Request ____Legal Proceedings

___Transfer of Care (reason for transfer) _____

Send Medical Records To/from: Dr Jerry Caporaso

1000 East Genesee Street
Suite 600
Syracuse, NY 13210
315-471-2713 315-471-1012 Fax

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Authorization will expire 12 months from the date of this authorization

PLEASE SEE THE BACK OF THIS FORM FOR IMPORTANT INFORMATION

Confidential HIV related information is any information indicating that a person had an HIV related test or has HIV infection, HIV related illness or AIDS, or any information which could indicate that person has been potentially exposed to HIV. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under Federal or State Law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release of disclosure of HIV-related, I may contact the New York State Division of Human Rights at (212) 480-2493 who is responsible for protecting my rights.

The practice will not receive payment or other remuneration from a third party in exchanged for using or disclosing the protected health information.

I do not have to sign this authorization in order to receive treatment from The Hill OB-GYN Associates, P.C. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. The Hill OB-GYN Associates, P.C., its employee, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 1000 East Genesee Street, Suite 600, Syracuse, NY 13210.

Request for a minor (under age 18) should be signed by the parent having legal custody or by legal guardian; except in situations protecting the minor's privacy as stated by NY State Health Code regulations. As a minor in New York State you may seek treatment for certain conditions without the knowledge or consent of her parents in alcohol or drug abuse cases, HIV/AIDS, venereal disease or certain other contagious diseases, pregnancy, or family planning and abortion. Only the minor may have access to medical record unless she specifically gives consent for her parents or guardian to obtain information. (See Decline Above)

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