Gianna OF ALBANY
AFFILIATED WITH THE NATIONAL GIANNA CENTER FOR WOMEN'S HEALTH AND FERTILITY™

# Authorization for Release of Medical Information

Name of Patient:_____ Date of Birth: _____

Address of Patient:_____ SS#: _____

Patient Telephone (Daytime) _____ (Evening)_____

I hereby authorize

_____

To release the information checked off below to: _____

Address: _____

Telephone No.:_____ Fax No.: _____

The following medical information covering the period(s) of treatment from:

_____ TO _____.
(Date) (Date)

**Information to be copied**_____ **Information to be inspected/reviewed**_____

☐ Complete Health Record(s)

☐ Progress Notes ☐ Consultation Reports

☐ Laboratory Tests ☐ Radiology Reports

Details if necessary)_____

☐ Full Summary

☐ Other: (Please Specify)_____

**I understand that this will include information relating to:**

☐ AIDS (Acquired Immunodeficiency Syndrome) or
HIV (Human Immunodeficiency Virus) Infection or tests for HIV Information (Use HIV DOH Authorization form # 2557)

☐ Other_____

☐ Not Applicable

**Purpose for Disclosure:**_____

Method of Delivery (check one): Pick Up ____ By Mail_____ By_ Fax_____

By signing below, I am requesting access to health information in the manner described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations. I understand that I will be contacted if any fees for copies, a summary or explanation may be charged for fulfilling this request, and that I will have an opportunity to modify or withdraw my request if I do not want to pay those fees.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire automatically six months from date on which it is signed. You have a right to refuse to sign this authorization. Your health care, the payment for your health care and your health care benefits will not be affected if you do not sign this form.

_____ _____

Signature of Patient, If Minor, Signature of Parent of Legal Guardian Relationship
Date

_____

Signature of Witness
Date

**NOTICE TO RECIPIENT:** This information has been disclosed to you from records whose confidentiality is protected by State & Federal Law. State & Federal regulations prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

## GENERAL INFORMATION

If your request is relevant to continued care by another physician or hospital, we will be glad to copy the information and forward it (fax) directly to another physician or hospital of your choice.