ORENTREICH MEDICAL GROUP

AUTHORIZATION FOR RELEASE OF RECORDS

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Patient's Name: _____ **MedRec Number:** _____
(for office use only)

We are unable to accept this authorization unless all items are completed.

1. This authorization becomes effective upon signing and will expire on (date) _____. If no date is indicated, this authorization will expire 1 year from signing date.

2. The information being disclosed may include office notes, consultation and treatment notes, correspondence, phone messages, medications, and test results, for the period from _____ to _____.

3. The following information will not be released unless the patient authorizes it by initializing below:

_____ HIV/AIDS records, including test results

_____ Drug/Alcohol abuse and mental health treatment records records, including test results

4. The information is to be released to: _____
(Name of person or facility)

_____
(Address of person or facility)

5. Reason for request: _____
(Information is disclosed for the following reason)

6. Format in which you would like to receive the records: _____ Paper Copy _____ Electronic Copy (CD)

The released information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

You have a right to revoke this authorization at any time, in writing, signed by you. Such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Your treatment or payment for your treatment cannot be conditioned on the signing of this authorization.

As set forth by Public Health Law 17 & 18, the fee for the copies of medical records is $0.75 per page; photo is $10.00 per photo. The copy of records will be provided in 10 business days.

The copies can either be picked up in person or mailed to the address noted above. We do not fax or e-mail copies of medical records.

Pick-up: The medical records can be picked up at the front desk by the patient in person. If the patient chooses to send someone else to pick up the records, the release of the records should be made to that person's name. The person will be asked to show ID at the time of pick-up.

Mail: We mail the records UPS ground to the address stated on this Authorization form. We will charge you a $20.00 flat rate shipping fee.

Signature of patient or legally authorized representative: _____ **Date**: _____

Name and relationship of legally authorized representative to patient: _____

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