LAKE CHAMPLAIN OB/GYN, PC

206 Cornelia St., Ste. 306, Plattsburgh, NY 12901
Phone: 518.566.9452 Fax: 518.562.7189

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
Consent for Use or Disclosure of Protected Health Information

Patient Name	**Date of Birth**	**Phone**
Patient Address	**City**	**State, Zip Code**

I authorize

Lake Champlain Ob/Gyn, PC
206 Cornelia St., Ste. 306, Plattsburgh, NY 12901

☐ RELEASE Information TO or ☐ OBTAIN Information FROM

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____ Phone: _____

Address: _____ City: _____ State, Zip Code: _____

Place an "X" in the box(es) that apply to the information you want released or you want to obtain.

☐ Annual Exam Notes ☐ GYN Exam Notes / Assessments ☐ Prenatal Records ☐ Diagnostic / Lab Results ☐ Operative Reports

☐ Medical Records from (insert date) _____ to (insert date) _____

☐ Other _____

Purpose of Disclosure: □ Change of Insurance or Physician □ Continuation of Care □ Legal Services □ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
2. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
3. Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.

Expiration: This authorization becomes effective immediately and shall expire on:_____. If no date is given, this authorization is valid for **12 months** from signature date.

In order to better serve our patients, your feedback is appreciated.

□ **I am not** transferring my care to this physician/facility on a permanent basis.
□ I am leaving Lake Champlain Ob/Gyn and transferring my care to this physician/facility permanently.
Reason for transferring from practice: □ Moving □ Insurance □ Dissatisfied □ Other _____

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed Name of Authorized Representative

Relationship / Capacity to Patient