# RELEASE OF INFORMATION AUTHORIZATION
## Refuah Health Center
## Fax Number 845.354.3305

| Patient Name: | Date of Birth: | Refuah Chart Number: |
|---|---|---|
| Street Address: | Other Name: | |
| City/State/Zip Code: | Telephone Number: | |

**I authorize the following facility/facilities to disclose individually identifiable health information about me.**

| | |
|---|---|
| _____ | _____ |
| **Facility Name** | **Facility Number** |
| _____ | _____ |
| **Facility Name** | **Facility Number** |
| _____ | _____ |
| **Facility Name** | **Facility Number** |

**To:**

Refuah Health Center
728 North Main St.
Spring Valley N.Y. 10977
845-354-9300 ext 1510

**Specific Information Requested:**

- o All Medical Records
- o Periods covering: From: To:
- o Other: (Please specify)

**Information is to be used for the purpose of:**

- o Continuing medical treatment

**This authorization shall expire 6 months from the date of the request. This authorization may be revoked by me at any time by a written or verbal notice to Refuah Health Center, except to the extent that Refuah Health Center has relied o the authorization.**
**Refuah Health Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.**
**I understand that there is always the potential that information Refuah Health Center disclosed to a third party under this authorization could be redisclosed by that third party and no longer valid under this authorization.**
**I further understand specific type of information to be disclosed may, if applicable include: Psychological Treatment, Diagnosis, Prognosis and treatment for Acquired Immune Deficiency Syndrome, Aids Related Complex, or Human Immunodeficiency infection for any date of service.**

| Signature of Patient or authorized Person: | Date: |
|---|---|
| Relationship of authorized patient: | |
| Print Name: | |
| Witness: | |