RELEASE OF INFORMATION AUTHORIZATION

Refuah Health Center
Fax Number 845.354.3305

Nombre de Paciente:	Fecha de Nacimiento:	Chart Number:
Dirección de Domicilio:	Other Name:	Email Address:
Ciudad/Estado/Código Postal:	Número de Teléfono:	Web enable: □Yes □No

I authorize Refuah Health Center to disclose, verbally, in writing or via the patient portal, individually identifiable health information about me, or the patient as listed above, to the following:

Please list any individuals and their address(es):	Please list any Provider/Facility and its address(es):

Información Específica Solicitada:

- ○ All Health Information, except _____
- ○ Other: (Please specify)

For the following to be included, indicate the specific information to be disclosed and initial below.	**Information to be Disclosed**	**Initials**
○ Records from alcohol/drug treatment programs		
○ Clinical records from mental health programs, including psychotherapy notes		
○ Clinical records from mental health programs, excluding psychotherapy notes		
○ HIV/AIDS-related Information		

- ○ Periods covering: From: To:
- ○ Other: (Please specify)

Information is to be used for the purpose of:

- ○ Continuing medical treatment
- ○ Attorney
- ○ Insurance
- ○ Other

Please check if information can be left on an answering machine:

□ Phone number_____ □ Other Phone number_____

This authorization shall expire 12 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 on the authorization. Refuah Health Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

This authorization may include disclosure of information relating to Alcohol and Drug Treatment, Mental Health Treatment, and Confidential HIV/AIDS-related information only if I place my initials on the appropriate line above. In the event the health information includes any of these types of information, and I initial the line on the box above. I specifically authorize release of such information to the person(s) indicated above.

With Some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

Firma de Paciente o Persona Autorizada:	Fecha:
Relación al Paciente o Persona Autorizada:	
Imprimir Nombre:	
Witness:	