Allied Physicians Rocky Point
A Division of Allied Physicians Group
346 Route 25A, Suite # 34 ● Rocky Point, NY 11778 Phone 631-315-7747 ● Fax 631-980-4144

Authorization for Use and Disclosure of Health Information

Incoming Medical Records Release/Request Form

Patient Name: _____ Date of Birth: _____

Address: _____
Street Number *City* *State* *Zip Code*

Phone Number: _____ *Note: This document must be made part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.

To the best of your knowledge, is the patient's vaccines up to date? ☐ Yes ☐ No

By signing this form, I hereby authorize: _____
Name of Provider/Facility Providing Information

_____
Address of party issuing information *Phone Number* *Fax Number*

to disclose the health information described below to:

_____
Name of Provider/Facility Providing Information

_____
Address of party issuing information *Phone Number* *Fax Number*

Check all that apply:

☐ All health information including but not limited to HIV related information and mental health records

☐ Health information relating to the following conditions or treatments: _____

☐ Health information for the following dates: _____

☐ Other specific description: _____

Reason for This Authorization:

Are you leaving this practice to transfer to another physician's office: ☐Yes ☐No

Reason for This Transfer/Authorization: _____

This authorization expires: ☐Upon Records Transfer ☐In 1 Year ☐Other: _____
(Indicate Specific Time Frame or Event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the office at the health care provider listed above as the issuing party.

Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

_____ _____ _____
Parent/Guardian/Legally Authorized Representative Signature *Print Name and/or Relationship to patient* *Date*