Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name: _____ Date of Birth: ____/ ____/ ____

I hereby authorize **CapitalCare Medical Group** to forward a copy of my Protected Health Information described below to:

_____

_____

_____

for the purpose(s) of: _____

Protected Health Information to be released: _____

Dates of care included: _____ to _____

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that CapitalCare Medical Group will not condition treatment on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by sending such written revocation to CapitalCare Medical Group. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

EXPIRATION DATE: This authorization will expire on (date no later than one year from now) _____.
(If no date is stated, this authorization expires six months from the date it was signed.)

COPY PROVIDED: CapitalCare Medical Group shall provide a copy of this signed authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

New York state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By initialing here_____, I authorize release of the following medical information that may be held by CapitalCare Medical Group: information pertaining to HIV disease, records of mental health care and treatment, records of care and treatment for sexually transmitted diseases and records of substance abuse care and treatment.

___/___/___	_____	_____
Date	Signature of individual patient or representative	Authority or relationship of representative