COMPASSIONATE FAMILY MEDICINE
AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address: _____ Date: _____

I hereby authorize to release my medical records to **Compassionate Family Medicine** from:

Facility/Physician: _____

Address: _____

Phone #: _____ Fax #: _____

Purpose For Disclosure: (Circle)

Continued Care Attorney/Legal Disability Determination Personal Uses

Insurance Claim/Application Transfer Care Other (Specify): _____

Include Information (if applicable) pertaining to: (Circle all that apply)

Mental Health Drug/Alcohol HIV/AIDS Communicable Treatment

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. **I understand Compassionate Family Medicine may charge a processing fee for this service.**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time exempt to the extent that the action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____ _____

Print Patient Name Date

_____ _____

Signature of Patient Legal Representative of Patient

311 Green Street
Syracuse, NY 13203
Main: 315-425-1431
Fax: 315-425-1994

511 N. Main Street
N. Syracuse, NY 13212
Main: 315-452-9977
Fax: 315-452-9607

138 E. Genesee Street
Baldwinsville, NY 13027
Main: 315-638-1950
Fax: 315-638-1445

2700 Court Street, Suite 4
Syracuse, NY 13208
Main: 315-760-6900
Fax: 315-425-1994