ADOLESCENT-YOUNG ADULT MEDICINE OF GREAT NECK, LLC

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HIPAA Compliant Authorization for Release of Medical Information

This form authorizes release of general medical information. (A separate form is needed for release of HIV-related medical information).

By checking the box below and signing this form, medical information can be given to the people listed on the back of this form. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

☒ I consent to disclosure of my general medical information

INFORMATION IN THE BOX BELOW MUST BE COMPLETED

Name and address of facility/person **disclosing medical information**:

____

Name of person whose information will be released:
____

Date of birth:
____

Name of person signing this form (if other than above):__________________________________

Relationship to person whose information will be released:______________________________

Describe information to be released:

__________COMPLETE MEDICAL RECORD______________________________________

Reason for release of information:

__________ONGOING CARE____

Time period during which information is authorized: From: ________________ To: ________________

____

All facilities listed on both sides of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.

Signature: X____ Date: X______________________

PLEASE COMPLETE OTHER SIDE

HIPAA Compliant Authorization for Release of Medical Information

Complete information for the facility/person to be given medical information.

Name and address of facility/person **to be given medical information**:

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TEL: (516) 482-5400 FAX: (516) 482-5400

Reason for release, if other than stated on the other side:

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If information to be disclosed to this facility/person is limited, please specify:

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My questions about this form have been answered. I know that I do not have to allow release of my medical information and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on the other side of this form to release medical information of the person named on the other side of this form to the facility/person listed above.

Signature: **X**______________________________ Date: **X**________________
(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: __________________________

Print Name: **X**____