



"Quality Care, Close to Home"

Clifton-Fine Hospital
P.O. Box 10
1014 Oswegatchie Trail
Star Lake NY, 13690
(315)848-3351
Fax:(315)848-2314

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I authorize Clifton-Fine Hospital (CFH) to use and/or disclose a copy of the specific health and medical information identified below for:

Name: _____ Date of Birth: _____

Name of Recipient: _____

Address: _____

Purpose: _____

I specifically authorize the use and/or disclosure of the following health information and/or medical records:

- Entire Medical Record, Laboratory Report, Emergency Room Record, History and Physical, Physician Progress Notes, Physician Orders, X-ray Report, CT Report, EKG, Discharge Summary, Pulmonary Function Study, Other:

Please note: HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) information can only be released with the completion of the Department of Health's authorization form.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department (Medical Records). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire (date or event): _____
(If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.)

I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

The requested information is for (date of service): _____

Signature of patient or legal representative

If signed by legal representative, relationship to patient

Signature of witness