Patient Medical Release & Disclosure

FIRST NAME | LAST NAME | DATE OF BIRTH

***Please Note**: This release is **NOT** valid for releasing/requesting your medical records to/from other providers.*

*This release, authorizes New York Allergy & Sinus Group, PLLC. to release to the **PATIENT** their medical records using one of the following methods:*

☐ Pick Up (Please indicate from which Office) _____

☐ Mail to home address on file

☐ Email

NOTE: Email is an inherently insecure form of communication. Please be aware that any sensitive information transmitted via email may be intercepted by a third party. If you request records to be sent through email, you are accepting the inherent security risks association with email communication.

Patient Designation Disclosure

Designation of certain relatives, close friends, caregivers, etc. as my Personal Representative.

HIPAA, states that your personal health information (PHI) cannot be shared unless you provide consent. You have the right to appoint one or more persons as your Personal Representative and you can limit the amount of information they receive. By completing and signing this section, you agree and approve that NYASC may disclose your health information to one or more of the personal representative(s) listed below as of the date signed. This Personal Representative Designation will remain in effect until you inform NYASC otherwise. To cancel this disclosure, you will be required to complete Revocation of Personal Representative, and all disclosure to the specified individual(s) will immediately seize.

NAME | RELATIONSHIP TO PATIENT | DATE

NAME | RELATIONSHIP TO PATIENT | DATE

NAME | RELATIONSHIP TO PATIENT | DATE

NAME | RELATIONSHIP TO PATIENT | DATE

NAME | RELATIONSHIP TO PATEINT | DATE

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY | NAME OF PATIENT OR RESPONSIBLE PARTY *(PLEASE PRINT)* | DATE

Confidential Information

If the requested portion of the record contains information pertaining to mental health, drug or alcohol treatment, or contains HIV related information, you must specifically authorize the release of such information by INITIALING the following three:

_____ I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization.

_____ I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form.

This consent may be revoked at any time by notifying the above-named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

THE CONTENTS OF THIS FORM ARE VALID FOR 1 YEAR FROM DATE OF SIGNATURE.

SIGNATURE OF PATIENT/LEGAL GUARDIAN (REQUIRED) | RELATIONSHIP TO PATIENT | DATE