AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

HIPAA COMPLIANT
(Code of Federal Regulations Title 45, Part 164.508)

Patient Name: _____

Date of Birth: _____

I, **_____**, hereby request and give my consent to authorize CHRISTIAN HEALTH SERVICE OF SYRACUSE, INC to release to:

_____ the following:

☐ Medical Records & Office Charts ☐ Consultation Reports ☐ Nurse's notes ☐ Medication & Allergy Lists ☐ Immunization Record ☐ Laboratory Reports ☐ Imaging Test Results & Reports ☐ Psychological Tests, Evaluations & Reports ☐ Billing & Payment Statements

☐ Alcohol/Drug Treatment ☐ Mental Health Information ☐ HIV-Related Information

This authorization is submitted per my request. I understand that any medical records released pursuant to this authorization may be released to the individual(s) as permitted or mandated by law.

This authorization expires: ☐ on _____ or ☐ is not intended to expire _____ **(initial)**

I further consent that a copy of this authorization has the same force and effect as an original _____ **(initial)**

I understand that I may revoke this authorization at any time prior to the expiration date, if any, by notifying the health care provider in writing by certified mail.

I understand I may refuse to sign this authorization. By signing my name below, I hereby acknowledge that I have read and fully understand this form. I acknowledge that I may refuse to sign this authorization and that I am signing this authorization voluntarily. I further understand that my health care provider(s) cannot condition medical treatment on whether I sign this authorization.

_____ Date: _____

Signature of patient or representative authorized by law