Crouse
MEDICAL PRACTICE, PLLC

739 Irving Ave
Suite 200
Syracuse, New York 13210
Phone: 315-479-5070
Fax: 315-701-2525

# REQUEST FOR RELEASE OF MEDICAL RECORDS

**Valid for 6 months from date of signature**

_____ _____ _____
Patient Name Date of Birth Social Security Number

**I hereby authorize and request the release of my medical records from Dr. _____**
**To: _____ Address: _____**
**_____**
**Fax number: _____**

**What:** Check all that apply
___All medical records, excluding HIV related information unless authorization is signed below.

___Mental Health Information ☐ ___Drug, Alcohol, Other Substance Abuse Information

___Other_____

**When:** From the period of _____ to _____

**Why:** For the purposes of: ☐ ___Review for current patient medical management ☐___Consultation ☐
___Transfer of Care ___Other _____

**Signature Patient/Guardian: _____ Date: _____**

**Relationship (If other than patient) _____**

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**HIV related Information:** Confidential HIV related information is any information that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State law, confidential HIV related information can only be given to people you allow to have it by signing a written release, or to people who need to know your HIV status in order to provide medical care and services, including: medical care providers, persons involved with foster care or adoption; parents and guardians who consent to care of minors; jail, prison, probation and parole employees; emergency response workers and other workers in hospitals, other regulated settings or medical offices, who are exposed to blood/body fluids in the course of their employment; and organizations that review services you receive. State law also allows your HIV information to be released under limited circumstances: by special court order; to public health officials as required by law; and to insurers as necessary to pay for care and treatment. Under State law, anyone who illegally discloses HIV related information may be punished by a fine of up to $5000.00 and a jail term of up to one year. However, some re-disclosures of such information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065.

The law protects you from HIV related discrimination in housing, employment, health care or other services. For more information, call the New York State Division of Human Rights Office of AIDS Discrimination Issues at 1-800-523-2437 or the New York City Commission of Human Rights at 212-306-5070. These agencies are responsible for protecting your rights.

You do not have to sign this form and you can change your mind at any time.

My questions about this form have been answered. I know that I do not have to allow release of HIV related information and that I can change my mind at any time.

**Signature to include HIV information: _____ Date: _____**

The Provider obtaining this release must complete the following. Note: Federal privacy regulations may restrict some consequences.

| Exceptions, if any, to the right to revoke consent for disclosure: (for example cannot revoke if disclosure has already been made.) |
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| Description of the consequences, if any, of failing to consent to the disclosure upon treatment, payment, enrollment, or eligibility for benefits: |