SYRACUSE GASTROENTEROLOGICAL ASSOCIATES, P.C.

CNY Medical Center, 739 Irving Ave, Ste 400, Syracuse, NY 13210 (315) 234-6677 fax (315) 234-4808
Liverpool office, 8324 Oswego Rd, Suite E, Liverpool, NY 13090 (315) 641-1966 fax (315) 641-1973

Date of Request:

Patient Name:	DOB:	SSN:

Patient Address:

Person Requesting Review (if other than patient):

This authorization will expire 24 months from the date of signature unless an alternate date is requested and noted below.
Expiration Date:

- ☐ I hereby authorize the Syracuse Gastroenterological Associates to use and/or disclose to the parties listed below:
  ____
  ____
- ☐ I hereby authorize ________________________ to use and/or disclose to the Syracuse Gastroenterological Associates.

Purpose of Release (disclosure). *Please check*:

- ☐ Sharing with health care providers as requested
- ☐ Personal Records
- ☐ Other (please describe): ________________________

Description of Information to be used or disclosed. *Please check*:

- ☐ Complete chart
- ☐ Other (please specify dates as well as visits, tests, etc.): ____________________

PLEASE FAX TO
315-234-4808

This authorization may include disclosure of information relating to ***ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV*-RELATED INFORMATION** only if I place my initials on the appropriate line below. In the event the health information described herein includes any of these types of information, and I initial the line below, I specifically authorize release of such information to the person(s) indicated above.*
Include:

_________**Alcohol/Drug Treatment** _________**Mental Health Information** ________**HIV-Related Information**

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information, which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

I understand that:

- **I may refuse to sign this authorization and that doing so is strictly voluntary.**
- **My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization if such conditioning is prohibited by the Privacy Rule.**
- **I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.**
- **If the requester or receiver is not a health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.**

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient:		Date signed:
Signature of Personal Representative:	Relationship (eg, Guardian, Custodial parent):	Date signed:

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