

# SYRACUSE GASTROENTEROLOGICAL ASSOCIATES, P.C.

CNY Medical Center, 739 Irving Ave, Ste 400, Syracuse, NY 13210 (315) 234-6677  
 Clay Medical Center, 8100 Oswego Rd, Ste 140, Liverpool, NY 13090 (315) 641-1966

OUR FAX NUMBER IS 315-234-4808

Date of Request:		
Patient Name:	DOB:	SSN:
Patient Address:		
Person Requesting Review (if other than patient):		
<i>This authorization will expire 24 months from the date of signature unless an alternate date is requested and noted below.</i> Expiration Date:		
<input type="checkbox"/> I hereby authorize the Syracuse Gastroenterological Associates to use and/or disclose to the parties listed below: _____ _____		
<input type="checkbox"/> I hereby authorize _____ to use and/or disclose to the Syracuse Gastroenterological Associates.		
Purpose of Release (disclosure). <i>Please check:</i>		
<input type="checkbox"/> Sharing with health care providers as requested <input type="checkbox"/> Personal Records <input type="checkbox"/> Other (please describe): _____		
Description of Information to be used or disclosed. <i>Please check:</i>		
<input type="checkbox"/> Complete chart <input type="checkbox"/> Other (please specify dates as well as visits, tests, etc.): _____		<b>PLEASE FAX TO</b> <b>315-234-4808</b>
<i>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.</i>		
Include:		
_____ Alcohol/Drug Treatment	_____ Mental Health Information	_____ HIV-Related Information
<small>*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.</small>		
<b>I understand that:</b>		
<ul style="list-style-type: none"> <li>• I may refuse to sign this authorization and that doing so is strictly voluntary.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul>		
<b>I have read the above and authorize the disclosure of the protected health information as stated.</b>		
Signature of Patient:		Date signed:
Signature of Personal Representative:		Date signed:
Relationship (eg, Guardian, Custodial parent):		

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