Integrated Medical Healthcare Services, PLLC
600 Stony Brook Ct
Newburgh, NY
Phone (845) 391-8557
Fax (833) 989-2507

Authorization for Release of Information

Patient Name **Date of Birth**

Street Address **Apt #** **City** **State** **Zip Code**

Phone # **Email Address**

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644.
3. I have the right to revoke this authorization at any time by writing to the releasing provider. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Unless revoked by written notice, this authorization will expire in one year.
4. Signing this authorization is voluntary. I understand that generally my treatment will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

INFORMATION REQUESTED FROM:

Provider/Group/Entity Name **Phone #**

Provider/Group/Entity Address **Fax #**

SEND INFORMATION TO:

Integrated Medical Healthcare Services, PLLC | 845-391-8557 | 833-989-2507

Person/Group/Entity Name **Phone #** **Fax #**

600 Stony Brook Ct, Newburgh, NY 12250 | frontdesk@imhcares.com

Person/Group/Entity Address **Secure Email Address**

INFORMATION TO BE DISCLOSED

- ☐ Medical records: ☐ past 3 years ☐ Date(s) of service: _____
- ☐ Entire medical record
- ☐ Records from alcohol/drug treatment programs; *Initials here:* ____
- ☐ Clinical records from mental health programs; *Initials here:* ____
- ☐ HIV/AIDS related information; *Initials here:* ____

PURPOSE OF DISCLOSURE

- ☐ Transfer or Continuity of care
- ☐ Personal Use
- ☐ Insurance or Disability claim
- ☐ Legal Case/Attorney

I, the undersigned, hereby authorize the release of health information as indicated above and declare that there is no court order restricting or prohibiting release of the requested records.

Signature of Patient or Authorized Legal Representative* **Date** **Relationship to Patient**

*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (e.g., court appointed guardian, durable power of attorney for health care). Exception: parent/guardian signing for a patient under the age of eighteen.