SOUTHGATE MEDICAL GROUP

1026 UNION ROAD, WEST SENECA, NY 14224 (716) 712-0851

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FROM THE PRACTICE

By signing this authorization, I authorize Southgate Medical Group (The Practice) to use and/or disclose certain protected health information (PHI) about me **to:**

1) Name and address of entity to receive this information:

_____

_____

2) This authorization permits The Practice to use and/or disclose the following individually identifiable health information about me (**specifically describe the information to be released**, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____

3) Reason for release of information: □ leaving our practice □ workers comp/no fault □ seeing a specialist □ life insurance □attorney

4) The following information will not be released unless specifically requested by initialing the item:

____ Chemical dependency records (records relating to alcohol or substance abuse)

____ Mental health records (including any care for anxiety or depression)

____ HIV related information (signed NYS form 2557 required)

- The information will be used or disclosed for the following purpose: Future medical care
- This authorization will expires in 90 days. This disclosure can be revoked at your request.
- I do not have to sign this authorization in order to receive treatment from The Practice.
- When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at The Practice address listed above.

The Practice charges a $0.75 per page fee for patients requesting records to continue care elsewhere. We also charge the same fee if the patient is requesting a copy for their own records.

5) Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient's Name — Date

_____ _____

Print Name of Patient or Legal Guardian — Date of Birth

Revised 10/16/07