Malta Med Emergent Care

6 Medical Park Drive, Malta, NY 12020

Authorization to Disclose Protected Health Information

Patient Name (First and Last): _____

Date of Birth: _____ Phone Number: _____

Address (Street, City, State, & Zip Code): _____

I hereby authorize Healthcare Partners of Saratoga, Ltd. doing business as Malta Med Emergent Care ("MMEC") to disclose or permit use of health information, as described below, concerning the above named individual. I understand that federal and state law offer special protection for information relating to **sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or the human immunodeficiency virus (HIV). Similar protections exist for information about behavioral or mental health services, and treatment for alcohol and drug abuse.** I understand that, if the health information covered by this authorization contains such information, I am waiving those protections in this instance by voluntarily authorizing use or disclosure of the health information.

The undersigned hereby authorizes MMEC to disclose my individual health information as described below. **(Check one)**

☐ **Copy of record** ☐ **Review Record**

The type and amount of information to be used or disclosed is as follows: Date(s) of visit: _____

☐ Summary ☐ Laboratory Results* ☐ Radiology Reports ☐ Radiology Films

☐ Discharge Summary ☐ History and Physical ☐ Mental Health

☐ Other: _____

Saratoga Hospital must obtain approval from the ordering physician before we can release lab tests. Telephone #: _____

DISCLOSE TO: _____

ADDRESS: _____

REASON/PURPOSE: _____

Check One: ☐ Pick-up ☐ By Mail ☐ By Fax, Fax #: _____ ☐ Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on _____. **If I fail to specify an expiration date, event or condition, the authorization will expire in 90 days.** I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

I understand the fee for copies of my medical record is $0.75 cents per page. This fee will be waived if the records are being sent to another physician or for continuing treatment.

_____ _____

Signature of Patient or Legal Representative Date / Time

_____ _____

If Signed by Legal Representative, Relationship to Patient Date / Time

_____ _____

Signature of Witness Date / Time

********** MALTA MED EMERGENT CARE USE ONLY **********

_____ _____

Signature of Staff Disclosing Information / Title Date / Time Completed

☐ Photo ID verified - Initials: _____ Medical Record Number: _____