CareNet Medical Group
2123 River Road
Schenectady, NY 12309
PATIENT HEALTH INFORMATION RELEASE AUTHORIZATION

Patient Name: _____ D.O.B. _____

I, or my authorized representative, request that health information regarding my care and treatment be release as set forth on this form. In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand the following:

If my records contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) related information, child abuse/neglect, sexual assault/abuse, termination of pregnancy, sexual preference, history of behavioral health counseling/family interaction problems, such information will be released pursuant to this authorization. Confidential HIV related information is any information indicating that HIV test was done; HIV virus is present; related illness of AIDS; or any information concerning Drugs or Alcohol abuse or treatment, or behavioral mental health services or Psychiatric treatment, such as information will be released pursuant to this authorization. Unless otherwise revoked, this authorization will expire in 90 days.

I understand that I have the right to revoke the 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 medical facility, I understand that the revocation will not apply to information that has already been released in response to this authorization.

Exception to the above, I do not authorize the release of the following:

Mental Health

HIV/AIDS

Substance Abuse / Alcohol Abuse

I understand that I may be charged a fee of $.75 per page for those records.

New York State Law requires an individual for the individuals authorized legal representative to specific consent for the release of protected health information related to certain condition. By my signature below, I authorize release of the following medical information that may be held by CareNet Medical Group, PC; information pertaining to HIV, records of mental health care and treatment, records of care and treatment of sexually transmitted disease and records of substance abuse care and treatment.

_____ _____
Date Signature of individual patient or guardian

Specific description of information:

1.
2. Mammography Disk/Films- ONLY

   Films to be RETURNED
   Permanent Release

3.
4. Transfer out of the Practice – ALL RECORDS – REASON FOR TRANSFER

   _____

5.
6. Only those records that contain the following specific information: _____

   _____

Records for the period from _____ /_____ /_____ to _____ /_____ /_____

Would you like to pick up your records: SCHENECTADY or CLIFTON PARK (**PLEASE CIRLE ONE**)

Would you like us to mail the information to you?

Would you like us to mail the information to Doctor's office?

Address: _____

Please select how you would like your records:

_____ PAPER COPY OR _____ ELECTRONIC COPY (Provided on CD)