Authorization to Use and Disclose Medical Information

Oneida Comprehensive Health Division

Name of Patient:____________________ Birthdate:____________________
Home Phone Number:__________________ Social Security Number:______________
Cell Phone Number:__________________ Work Phone Number:__________________

By signing this form, I authorize Oneida Comprehensive Health Division to use and disclose my medical information to:

Name

______________________ [ ] Dental [ ] Medical* [ ] Optical [ ] Pharmacy (Drop off/Pick Up Only)
______________________ [ ] Dental [ ] Medical* [ ] Optical [ ] Pharmacy (Drop off/Pick Up Only)
______________________ [ ] Dental [ ] Medical* [ ] Optical [ ] Pharmacy (Drop off/Pick Up Only)
______________________ [ ] Dental [ ] Medical* [ ] Optical [ ] Pharmacy (Drop off/Pick Up Only)
______________________ [ ] Dental [ ] Medical* [ ] Optical [ ] Pharmacy (Drop off/Pick Up Only)
______________________ [ ] Dental [ ] Medical* [ ] Optical [ ] Pharmacy (Drop off/Pick Up Only)
______________________ [ ] Dental [ ] Medical* [ ] Optical [ ] Pharmacy (Drop off/Pick Up Only)

*Information released under Medical is Provider Notes of Medical History, Examination; Surgical Reports; Progress or Discharge; Hospital Records Including Reports; Tests and Results; Allergy Records; Immunizations; Prescriptions; Radiology Reports; Consultations; Laboratory Reports; Appointments, Medical Supplies and Purchased Referred Care.

In addition, I specifically authorize the release of records pertaining to:

[ ] Mental Health [ ] HIV (AIDS) [ ] Substance Abuse [ ] Developmental Disabilities

[ ] Other (Specify) For the Following Date(s):______________________________

COMMUNICATIONS: Please check the boxes below to indicate your consent:

[ ] Mail [ ] Call [ ] Leave Message [ ] Other (Specify)______________________________

HOW THIS FORM MAY AFFECT ME AND MY RIGHTS:

Right to Revoke Authorization. I understand that I have the right to revoke this authorization, except to the extent that Oneida Comprehensive Health Division has already used or disclosed my medical information in reliance of this authorization. I understand that my revocation is effective only if it is in writing. To revoke my authorization, I understand that I must send a written request for revocation to Oneida Comprehensive Health Division medical records staff.

Right to Inspect and Copy My Medical Information. I understand that I have the right to inspect and copy my medical information in Oneida Comprehensive Health Division records. I understand that to inspect and copy medical information, I must submit my request in writing to Oneida Comprehensive Health Division medical records staff. If I request a copy of the information, I understand that Oneida Comprehensive Health Division may charge a reasonable cost-based fee in accordance with applicable law to fulfill my request. I understand that Oneida Comprehensive Health Division may deny my request to inspect and copy in certain very limited circumstances. If I am denied access to medical information, I may request that the denial be reviewed in certain circumstances.

I Am Not Required to Sign this Authorization. I understand that I may refuse to sign this authorization may or may not affect my ability to obtain treatment at Oneida Comprehensive Health Division. However, I also acknowledge that I have agreed to sign this authorization.

This authorization will remain in effect until I chose to revoke.

Signature of Patient

Signature of Legal Representative

Signature Date:_____

If signed by a Legal Representative, complete the following:
The individual is: [ ] a minor [ ] legally incompetent or incapacitated [ ] deceased

Legal authority: [ ] parent* [ ] legal guardian [ ] next of kin/executor of deceased [ ] activated POA for Health care

*By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order.