AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name (LAST, FIRST, M.I.)

SEX _____ DATE OF BIRTH _____

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and Federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth in 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. In the event the health information described below includes any of these types of information, and I initial the line corresponding to that information, I specifically authorize release of such information to the person(s) indicated below.
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, specifically referring to Title 42 of the Code of Federal Regulations governing the confidentiality of these types of records.
3. I have the right to revoke this authorization at any time by writing to The Chautauqua Center. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that my refusal to sign will not affect my abilities to obtain treatment from The Chautauqua Center.
5. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR Pts. 160, 164 and NYS Mental Hygiene Law 33.16).

To/ From:	To/ From:
The Chautauqua Center/Chautauqua Physical & Occupational Therapy 15 S. Main St. Suite 220 Jamestown, NY 14701 Phone (716) 488-2322 Fax (716) 488-2574 99 East Chautauqua St. Mayville, NY 14757 Phone (716) 224-4099 Fax (716) 224-4999 51 East Third St. Dunkirk, NY 14048 Phone (716) 363-2244 Fax (716) 363-2245	

Purpose for release of Information: Continuation of care at The Chautauqua Center.

Unless previously revoked by me, the specific information below may be disclosed from: _____ (date) until I no longer am receiving services from The Chautauqua Center, if I have initialed under the specific area.

Medical	Dental	Mental Health	Substance Abuse	HIV/AIDS

If not the patient, name of person signing form (Printed):	Authority to sign on behalf of patient:
Patient Signature: I certify that I authorize the use of my health information as set forth above.	Date:

Form revised September 30, 2022