HARRISON MEDICAL GROUP
106 CALVERT STREET
HARRISON, NEW YORK 10528

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient: _____

Date of Birth: _____

I hereby authorize medical providers and personnel of **HARRISON MEDICAL GROUP** to discuss my protected health information with:

_____ (Relationship)	_____ (Name)
_____ (Relationship)	_____ (Name)
_____ (Relationship)	_____ (Name)

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

____ Information regarding the patient's diagnosis and treatment for HIV/AIDS
____ Psychotherapy notes from a Psychiatrist or Psychotherapist
____ Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from _____ until _____ at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient/Personal Representative Name of Patient/Personal Representative

_____ _____
Date Description of Personal Representative's Authority

updated 5-08