Center for Disability Services
Where people get better at life

Center Health Care

AUTHORIZATION TO **OBTAIN & RELEASE** PROTECTED HEALTH INFORMATION

This authorization is written permission for an outside agency to disclose Protected Health Information (PHI) as directed.

Print Patient Name & Address

Patient Name:_____ Phone: ( )_____

Former/Maiden Name:_____ DOB:_____/_____/_____

Address:_____
Street City State Zip

Name of Agency Sending Records to CHC

I, _____ hereby authorize _____

Address:_____
Street City State Zip

Phone: ( )_____ Fax: ( )_____

to disclose Protected Health Information (PHI) **TO**: **Provider Name** _____

Center Health Care
ATTN: Medical Records Department
314 So. Manning Blvd.
Albany, NY 12208
Phone: (518) 437-5710 Fax: (518) 437-5711

Indicate specific information to be disclosed

The specific information to be disclosed, includes: (describe the information, including but not limited to, descriptors such as date of services, type of service, level of detail to be released, etc.)

☐ Entire Medical Record

☐ Copies of Progress Notes from _____ (Provider/Specialty)
for the following dates:_____

☐ Immunizations

☐ Tests/Evals :_____ : ____/____/____ ____/____/____
Type of Test/Eval Date Date

☐ Verbal exchange between:_____ /_____ and
Name of Individual Agency
_____ at Center Health Care.

☐ Other (please be specific):_____
_____

The PHI is being disclosed for the following purposes:

☐ Change of Provider ☐ Verbal Exchange ☐ At my request ☐ Other: _____

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure (with the exception of HIV information) and may no longer be protected by state or federal law. I understand that this authorization **will expire one (1) year from the date of signature** unless a shorter period is noted here.

SIGN AND DATE HERE

_____ _____ _____/_____/_____
Signature of Patient or Legal Representative Relationship to patient/representative's authority Date

Revised July 2024