HOBART AND WILLIAM SMITH COLLEGES

Finger Lakes Health

Hubbs Health Center
119 St. Clair St., Geneva, NY 14456
E-mail: Hubbs@hws.edu Phone: 315-781-3600 Fax: 315-781-3802

Authorization for Release/Use of Medical Information

Patients Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Purpose of this request: (circle ONE)
Healthcare/Appointment, Patient Request, Insurance, Other

This Authorization allows Hubbs Health Center to: (CHECK ONE)
_____ *Send copies of your record TO (or discuss your information with) the provider/person/facility below…*
_____ *Receive copies of your record FROM (or discuss your information with) the provider/person/facility below…*

Name of Provider/Person/Facility:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Type of Records/Information Requested: (Check ALL that apply)
Inpatient/Outpatient (place, date, time of service, if applicable)

_____Discharge Summary_____Medication and Problem List _____History and Physical

_____Office Notes and Consult Notes _____ Tests and Reports _____ Labs and Imaging

I understand that this authorization may include discloses of information relating to alcohol and drug and mental health treatment (except psychotherapy notes) only if I place my initials on the appropriate line below. If I am authorizing the release of alcohol or drug treatment or mental health information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so by state law.
_____ Alcohol/Drug Treatment _____ Mental Health Information

Authorization Valid For: (is nothing is checked, this authorization is valid for this request only.)
This request is valid for one year from the date of this authorization or _____. I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization. If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above you be redisclosed by the recipient. Release of HIV-related information required an additional authorization. There may be a change for the requested records. The medical records requested above may be faxed or e-mailed in cases of medical necessity.

Signature of Patient/Representative: _____ Date: _____