Cross Keys Internal Medicine, LLP

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name:		
Telephone#		Date of Birth: / /
Reason for Disclosure: (Check box below)		SS#:
	Transferring Care	Current Address:
	Communication with Family	Street:
	Per patient Request	City: State: Zip:
	Other	Telephone #:

I hereby authorize Cross Keys Internal Medicine, LLP, its officers, employees, agents, contractors, partners or affiliates entrusted with handling medical records (the "Covered Entity") to release the health information indicated below (check appropriate box) that is contained in my patient records to:

Release Information FROM:		Release Information TO:
Name:		Name:
Address:		Address:
City/State/Zip:		City/State/Zip:

I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and other tests or diagnoses.

	Entire Medical Record Including Progess Notes, Labs and Reports		General Medical Health Information (to speak with family members)
	Only Specified Records (Must Specify Below):		Specified Dates (Must Specify Below):

Please note that only health information generated in this office will be released. This excludes previous old records and records generated by other physicians (including consultants).

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at 420 Cross Keys Office Park, Fairport, New York 14450. I understand that revocation of this authorization is not effective to the extent that the Covered Entity has relied upon it for the use or disclosure of Protected Health Information prior to receiving my written revocation notice.

This authorization and consent will expire one year from the date of authorization written below.

I acknowledge that the Covered Entity will not condition my treatment or payment on whether I sign this authorization unless the health care that the Covered Entity is providing is being provided solely for the purpose of providing the Protected Health Information to a third party.

I acknowledge that any Protected Health Information disclosed pursuant to this authorization to an individual or entity that is not covered by the state and federal privacy laws and regulations may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature of Patient/Legal Guardian	Printed Name
Description of Personal Representative's Authority	Date Signed

A SIGNED COPY OF THIS AUTHORIZATION MUST BE PROVIDED TO THE PATIENT OR THE PATIENT'S REPRESENTATIVE.