

Queenan Family Medicine and Maternity Care

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"Mindful Medicine for whole body, mind, and spirit"
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Patient Phone #: () _____ Date of Birth: _____

I authorize Queenan Family Medicine and Maternity Care to **release information to:**

Name of provider or facility

Address

City, State, Zip

Phone # / Fax # (include area code)

I authorize Queenan Family Medicine and Maternity Care to **obtain information from:**

Name of provider or facility

Address

City, State, Zip

Phone # / Fax # (include area code)

1. Purpose of this request: (check one)

Healthcare Insurance Coverage Personal Transfer of Care Other

2. The type and amount of information to be used or disclosed is as follows:

(check one, and include dates where appropriate)

Immunization History

All medical records related to a specific illness or injury

(specify illness or injury and date(s) of treatment) _____

Treatment Summary (includes history/physical, laboratory tests, X-ray reports, operative reports, pathology reports)

Specific information (select one or more, as applicable)

Most recent history and physical

Procedure report

Most recent discharge summary

Laboratory results from (date) _____ to (date) _____

X-ray and imaging reports from (date) _____ to (date) _____

Consultation reports from (doctor's names) _____

Other (please describe) _____

Entire copy of the record checked above

3. Additional authorization for sensitive information

I specifically authorize the release of information regarding the following condition(s):

Initials

_____ Substance abuse diagnosis and treatment, if any

_____ Mental Health services, if any

_____ HIV-related information, if any

_____ Sexually transmitted infections, if any

4. Authorization valid for: (check one)

This request only

One year from the date of this authorization **OR** (insert date) _____.

(This authorization applies to the records of the treatment received on or prior to the date of this authorization.)

This request **and** for medical records of any **future** treatment of this type described above until: (insert date) _____.

5. I understand that:

My right to healthcare is not conditioned on this authorization.

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.

I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the pending of my claim or lawsuit.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed,

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as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: U.S. Department of Health and Human Services Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C., 20201 – Phone: (866) 627-7748 – Web: www.hhs.gov

- 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 could be redisclosed.
- Release of HIV-related information, information about sexually transmitted infections, mental health services, or substance abuse diagnosis and treatment requires additional authorization.
- There may be a charge for the requested records.

5. You are further authorized to discuss my case in detail with:

or their representatives, and assist them in any way they may request your services.

Signature of Patient or Legal Representative Date

If Signed by Legal Representative, Signature of Witness

Relationship to Patient

A photocopy of this Authorization will be considered as an original.