Clifton-Fine Hospital

A SAMARITAN HEALTH PARTNER

Trusted Care. Close to Home.

Clifton-Fine Hospital
1014 Oswegatchie Trail
Star Lake, NY 13690
PHONE: (315)848-3351 FAX: (315)848-2835

AUTHORIZATION TO USE AND DISCLOSE MEDICAL RECORDS

I authorize_____ to use and/or disclose a copy of the specific health and medical information identified below for.

Client Name: _____ Date of Birth___/____/_____

Name of Recipient: Clifton-Fine Clinic
1014 Oswegatchie Trail, Star Lake New York 13690

For the following purpose: continued Medical Care or _____

I specifically authorize the use and/or disclosure of the following health information:

_____ Entire Medical Record	_____ Lab Report	_____ Physician Orders
_____ History / Physical	_____ Radiology Reports	_____ Consultations
_____ Physician Notes	_____ Respiratory Reports	_____ Medication Records
_____ Allergy Shot Record	_____ Immunization Records	_____ Other

- I understand that I have a right to revoke this authorization at any time.
- I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Department.
- I understand that the revocation will not apply to information that has already been released in released in response to this 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.

I understand authorizing the use or disclosure of the Information Identified is voluntary. I need not sign this form to ensure healthcare treatment.

The request information is for (Date of Service) _____
Signature of patient/legal representative: _____
Legal reprehensive relationship: _____
Date of signature: _____ Expiration Date: _____

- If I fail to specify an expiration date or event, this authorization will expire six months from the date signed.
- Please note: HIV/AIDS Information can only be released with the completion of the NYS
- Authorization forms.
- Original is filed in PATIENTS Medical Record, copy to accompany request.

Date Requested_____ Date Received _____