Northway Medical Associates

21 N 2nd Street
Fulton, NY 13069
P 315-598-7105
F 315-598-4857

3070 Belgium Road
Baldwinsville, NY 13027
P 315-635-5700
F 315-635-5313

Release of Health Information

I hereby authorize:____
Records of:____

Patients Name:____ DOB:____________________
Address:____ Telephone:______________________
____ Acct #:_________________________

Covering the Period(s) of healthcare:
From Date: ________________________ To Date:______________________

Information to be received/disclosed:

- [ ] Complete health record(s)
- [ ] History & Physical Examinations
- [ ] Progress Notes
- [ ] Laboratory Tests
- [ ] Discharge Summary
- [ ] Consultation Reports
- [ ] X-Ray Reports
- [ ] Other (please Specify)_________________________

I understand that this will include information relating to (check if applicable):

- [ ] Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)
- [ ] Psychiatric Care
- [ ] Treatment for alcohol and/or drug abuse

This information is to be received/disclosed to: ____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____________________________________

The ___________________________, employees, consultants, volunteers, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Name (print):____
Signature:____ Date:____________________
Or Legal Representative:____
Relationship to Patient:_______________________________________ Date:____________________