ST PETER'S HEALTH PARTNERS
Medical Associates

Medical Records Fax: 1-833-548-4509
Mail to: 425 New Scotland Ave
Albany, Ny 12208

Authorization for Release of Medical Records

1. I hereby authorize ST PETER'S MEDICAL ASSOCIATES to disclose information from the medical record of:
   Patient Name:_____ AKA:_____ Date of Birth:_____
   Address:_____ Phone Number:_____
   _____ Social Security Number:_____
   Covering the period of healthcare From **(date)**:_____ To **(date)**:_____
   Type of Visit(s): ☐Inpatient ☐Outpatient ☐Emergency Room ☐Other_____

   Information to be Disclosed:
   ❒ Complete Medical Records ❒ Discharge Summary ❒ History & Physical
   ❒ Progress Notes ❒ Consultation Reports ❒ Laboratory Tests
   ❒ Intake Evaluation ❒ Operative Report ❒ Provider Orders
   ❒ Medication Records ☐ Medical Imaging Reports (ie: X-ray, MRI, CT Scan)
   ❒ Other (please specify):_____ ☐ Therapy Notes
   I understand that this will include information relating to (as applicable; including testing for):
   AIDS (acquired immunodeficiency syndrome) HIV (human immunodeficiency virus) Infection
   Behavioral Health Service/Psychiatric Care Treatment for Alcohol and/or Drug Abuse
2. **This information is to be disclosed to:**
   Name:_____
   Address:_____
   _____
   For the purpose of:_____
3. I understand that treatment will not be conditioned on the execution of this authorization. I understand that 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 six months from the date of signature, or on the following date, event or condition: Specify: _____
   _____
4. I understand that information released pursuant to this authorization is governed by State and Federal confidentiality laws, however some re-disclosures of information are not protected under Federal Law.
5. I understand that any disclosure of drug and alcohol related information is bound by Federal Law 42 Part 2 CFR governing confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information to a party other than the one designated above is forbidden without my additional written authorization.
6. Under State law, anyone who illegally discloses HIV related information may be punished by a fine of up to $5,000 and a jail term of up to one year. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein.

Signature of Patient:_____ Date:_____ Time: _____
(or legal representative)

Relationship of Representative to Patient: _____

Signature of Witness:_____ Date:_____ Time: _____

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Revocation of **Authorization for Release of Medical Records**

1. I hereby revoke my previous authorization to St. Peter's Medical Associates to disclose information from the medical records as detailed on the front of this form.

2. I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases.

3. St. Peter's Medical Associates, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

Signature of Patient:_____ Date:_____ Time: _____
(or legal representative)

Relationship of Representative to Patient: _____

Signature of Witness:_____ Date:_____ Time: _____