HEALTHQUEST
Medical Practice

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
THERE MAY BE A PROCESSING FEE ASSOCIATED WITH THIS REQUEST

PATIENT NAME:____
Last First

ADDRESS: ____
Street City State Zip

DATE OF BIRTH: ______________________ **PHONE NUMBER:** ______________________

I hereby authorize **Health Quest Medical Practice** to **RELEASE** my protected health information to:

NAME: ______________________________ **PHONE NUMBER:** ______________________

ADDRESS: ____
Street City State Zip

I hereby authorize Health Quest Medical Practice to **RECEIVE** my protected health information from:

NAME: ______________________________ PHONE NUMBER: ______________________

ADDRESS: ____
Street City State Zip

Please send information back to:____

Information Requested:

❑ All Records ❑Progress Note ❑ Immunization Record ❑ Operative/ Pathology Report
❑ Labs ❑ Radiology ❑ History & Physical
❑ Other: ____

Approximate Date(s) of Treatment: ____

Include: (Initial) ____ Alcohol/Drug Treatment; ____ Mental Health Information; ____ HIV-Related Information

Reason for release of information: Continuation of Medical Care; Processing of a Claim; □ Other ________

In accordance with New York State and Federal Laws, I understand that: This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line. In the event the health information described above includes any of these types of information, and I initial the line, I specifically authorize release of such information to the person(s) indicated herein. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights. I have the right to revoke this authorization at any time by writing to the health care provider listed herein. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above), and this re-disclosure may no longer be protected by federal or state law. All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

SIGNATURE OF PATIENT/ AUTHORIZED REPRESENTATIVE:______________________________Date__________

PLEASE PRINT NAME CLEARLY:____

DATE/EVENT THAT THIS AUTHORIZATION WILL EXPIRE: ______________________________
(*If expiration date left blank, this authorization will expire in six (6) months from the date of this request*).