

CARENET MEDICAL GROUP, PC
AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH
INFORMATION
As Required by the Privacy Regulations Created as a Results of Health Insurance
Portability and Accountability Act of 1996(HIPAA)

I authorize CareNet Medical Group to obtain my medical information as directed below.

Patient's Full Name: _____ Date of Birth: _____

I hereby authorize CareNet Medical Group, PC to obtain Protected Health Information
From: _____

Address: _____

Telephone: _____ Fax: _____

Please specify the Protected Health Information to be released:

Medical Records [] Dates of care include: _____ To _____

Mammography films [] This is a permanent release of films: YES or NO

The mammogram I am requesting was completed at your facility under the name of:

(If name is Different from above)

1. I understand that I may inspect or obtain a copy of the Protected Health Information described by this authorization

2. I understand that the information may include sensitive information such as alcohol and drug usage, child abuse / neglect, sexual assault / abuse, sexually transmitted disease, termination of pregnancy, sexual preference, and history of behavioral health counseling / family interaction problems. **ANY INFORMATION NOT TO BE RELEASED SHOULD BE SPECIFIED:**

EXPIRATION DATE OR EVENT: This authorization will expire on (date no later than one year from now)_____.

Please forward my Protected Health Information To:

CARENET MEDICAL GROUP, PC
Attention: Medical Records Department
2123 River Road
Schenectady, New York 12309

Date

Signature of individual patient or guardian