

Sunrise Medical
Dr. Amy J. Burke
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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please allow 10-14 business days for processing. There is a fee of .75 cents per page for copies of medical records.

The medical records cannot be released until this form is completed and signed by the patient or legal guardian.

You must complete this form thoroughly.

PLEASE PRINT

Step I: Patient Name _____ Date of Birth _____

Address _____

Street City State Zip Code

Step II: I hereby authorize Amy J Burke MD PC _____ to release **OR** _____ obtain my health information **FROM:**

Name of Physician/Medical Facility _____

Address _____

Street City State Zip Code Phone # Fax #

Step III: Information to be released:

_____ Medical Record from (date) _____ to (date) _____

_____ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, referrals, consults, billing records, insurance records, and records sent by other health care providers.

_____ OTHER: _____

PLEASE INITIAL BELOW TO INCLUDE THE FOLLOWING:

_____ ALCOHOL/DRUG TREATMENT

_____ MENTAL HEALTH INFORMATION

(EXCLUDING psychotherapy notes)

_____ HIV- RELATED INFORMATION

_____ GENETIC TESTING

(must be accompanied by NYS DOH-2557)

Step IV: Purpose for disclosure is at the request of the individual based on the following: *(This section must be completed before records will be released)*

_____ **Transfer of Care** Reason: _____

_____ **Continuity of Care**

Step V: CONDITIONS OF AUTHORIZATION

I have the right to revoke this authorization at any time by writing to the health care provider listed above. 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 form 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 used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations.

A copy of this authorization has been provided.

This authorization is valid for 90 days for the release of information as indicated by date of signature below.

Patient Signature & Date

If not the patient, name and authority to sign on their behalf

~~~~~For office use only~~~~~

Total Pages \_\_\_\_\_ @ .75/page (+ postage \_\_\_\_\_ ) = \_\_\_\_\_ TOTAL COST or \_\_\_\_\_ FLAT FEE

Prepayment – Bill MAILED or FAXED on: \_\_\_\_\_

Records MAILED or FAXED on: \_\_\_\_\_