Hilton Health Care, P.C
279 East Avenue
Hilton, NY 14468
Ph: (585) 392-9100 F: (585) 392-6292
www.hiltonhealthcare.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize **Hilton Health Care, P.C** to:

Please complete address below:

☐**SEND** my records to: _____
☐**OBTAIN** my records: _____
☐**PICK UP** my own records: _____
Phone: _____ Fax: _____

Reason for release:

☐**I am transferring care**
Reason: _____

☐**I am NOT transferring**
Purpose of this request is: _____

PLEASE SEND: *I understand that HHC can charge up to 75¢ per page (maximum of $50) for copying my clinical records (except for record being sent to a referring specialist)*

☐**ALL RECORDS** (including mental health, HIV, and substance abuse)
☐do not send mental health, if any
☐do not send HIV related information, if any
☐do not send drug/substance abuse records, if any

☐**SPECIFIC INFORMATION**: _____
(please be as specific as possible)

AUTHORIZATION VALID FOR: Unless otherwise revoked, this authorization will expire on the following date: _____. If I fail to specify an expiration date, event, or condition, **this authorization expires one year** from the date of signing.

I understand that:

- If I am transferring out, HHC will no longer be responsible for my care once my clinical records have been released to my new provider or myself and, that I will not be accepted back as a patient unless I am transferring for insurance reasons or moving out of the area.
- I may cancel this authorization at any time by submitting a written request. I understand that the cancellation will not apply to information that has already been released in response to this authorization
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If I wish, I can receive a copy of this authorization form, after signing.

Signature: _____ Date: _____

Relationship to patient if under 18: _____