CAPITAL DISTRICT
Vitality Center

Authorization to Release Medical Records

Name of Patient_____ Date: _____/_____/_____

Date of Birth ____/_____/_____ Social Security Number _____-_____-_____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care	Military	Social Security/Disability
Insurance	Personal Use	Other: _____
Legal Purposes	School	_____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge/Death Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	Other: **Any/All Blood Labs from Last 6 Months**

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

Dr. Richard Herbold	**518-371-6431**	**518-383-5245**
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)	Phone Number	Fax

140 Lapp Road, Clifton Park, NY 12065
Address (Street, City, State and ZIP)

FROM:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re- disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: ____/____/_____ Signature: _____
Patient or Legally Authorized Representative

_____ _____
Printed Name of Patient or Legally Authorized Representative
Relationship to Patient