TULLY HILL TREATMENT & RECOVERY
AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH INFORMATION

PATIENT LABEL

I authorize *Tully Hill Treatment & Recovery, P.O. Box 1116, Tully, NY 13159 [phone number: (800) 456-6114 fax number: (315)696-8509 email: medrecfax@tullyhill.com]* ***and only the following recipient to communicate with and disclose to one another*** *my health information, including information about substance use disorder and mental health/co-occurring disorders.*

I authorize disclosure to:

Person/Organization: _____ **Relationship:** _____
Full Address: _____

_____

Telephone Number: _____ **Fax Number:** _____

Yes No **I consent to disclosure of my HIV-related information.**

I authorize disclosure of the following information: *(**Initial** next to the items to be released)*

_____The fact that I'm here, how I'm doing and if I've been discharged
_____Medical records (minimum necessary for my care)
_____Other (specify):_____

The purpose *of this disclosure is for/to: (**Initial** next to the items that pertain):*

_____ Continuity of Care
_____ Keep Significant Others Involved Informed
_____ Keep Employer/School Involved
_____ Insurance/Disability/Legal Issues
_____ Update Medical Records
_____ Other _____

The method of disclosure may include telephone contact, mail, fax and hand delivery, unless there is a clearly written restriction here: _____

This consent shall automatically expire 12 months after my discharge *from Tully Hill, unless I specify a different time period, event, or condition here (in which case such shall apply to the expiration of this authorization).* Alternate time period, event, or condition: _____

All items on this form have been completed and my questions about this form have been answered. I have been provided a copy of this form if I so requested. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing to Tully Hill or notifying a staff member.

_____ Date: _____
Patient's Signature

_____ Date: _____
Witness's Signature (parent/legal guardian signature if patient is an unnemancipated minor)

_____
Patient's Printed Name

_____
Patient's Date of Birth

This disclosure is subject to state and federal laws and regulations, including, but not limited to, NYS Public Health Law Section 17, 18 and 27, 42 CFR and 45 CFR. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Disclaimer: The federal ESIGN Act provides that any law with a requirement for a signature may be satisfied by an electronic signature. Electronic signatures are legally binding in New York State under the Electronic Signatures and Records Act and have the same legal validity as handwritten signatures.