ROCHESTER CENTER FOR SEXUAL WELLNESS

625 Panorama Trail ◊ Building 3 Suite 3200 ◊ Rochester, NY 14625 ◊ Phone: 585 865 3584 Fax: 844 765 5645

Authorization for Release of Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Patient's Phone: _____

City/State/Zip: _____

This Authorization allows the Rochester Center for Sexual Wellness to: (check one or both)

☐ **SEND** copes of your record (or discuss your information with) the provider/person/facility below

☐ **RECEIVE** copies of your record from (or discuss your information with) the provider/person/facility below

1) _____ Address/Phone/Fax: _____
PRIMARY CARE

2) _____ Address/Phone/Fax: _____
Specialist

3) _____ Address/Phone/Fax: _____
Specialist

If your provider is part of the URMC system, we can access some records through ePartner. If you consent to this access, please provide the last 4 digits of your social security number: _____

Purpose for the request: Healthcare

Type of records or information requested: (Release disclosure of HIV-related information requires additional authorization on form NYS DOH2557 or OCA 960)

☐ Mental Health Treatment Records: ☐ Substance Abuse ☐ Psychosocial/Psychiatric Evaluation/Assessment ☐ Current Treatment Update ☐ Presence/Participation in Treatment ☐ Discharge/Transfer Summary ☐ Psychotherapy Notes

☐ Medical Outpatient/ Office visits: Last office visit, last complete physical exam, most recent labwork or imaging

☐ Other: _____

Authorization valid for one year from the date of this authorization OR date: _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization, except in very limited circumstances.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed, except that chemical dependency treatment records protected by Federal Confidentiality Rules 42CFR Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.
- There may be a charge for requested records.
- The medical records requested above may be faxed in cases of medical necessity.

Printed Client Name:	
Client Signature:	Date: