Refuah

RELEASE OF INFORMATION AUTHORIZATION
Refuah Health Center
Fax Number 845.354.3305

Patient Name:	Date of Birth:	Chart Number:
Street Address:	Other Name:	Email Address:
City/State/Zip Code:	Telephone Number:	Web enable: □Yes □No

I authorize Refuah Health Center to disclose, verbally, in writing or via the patient portal, individually identifiable health information about me.

Please list any Family Members:	Please list any Facility Name: Telephone # _____ Fax # _____

Specific Information Requested:

- o All Medical Records
- o Other: (Please specify)
- o Periods covering: From: To:
- o Other: (Please specify)

Information is to be used for the purpose of:

- o Continuing medical treatment
- o Insurance
- o Attorney
- o Other

728 North Main Street
5 Twin Avenue
Spring Valley, NY 10977
100 Rt 59-Suite 105
Suffern, NY 10901
Tel: 845 354 9300
Fax: 845 354 3305
refuahhealthcenter.com

Refuah

Please check if information can be left on an answering machine:

☐ **Phone number**_____ ☐ **Other Phone number**_____

This authorization shall expire 6 months from the date of the request. This authorization may be revoked by me at any time by a written or verbal notice to Refuah Health Center, except to the extent that Refuah Health Center has relied on the authorization.

Refuah Health Center will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that there is always the potential that information Refuah Health Center disclosed to a third party under this authorization could be re-disclosed by that third party and no longer valid under this authorization.

I further understand that the specific type of information to be disclosed may, if applicable include: Diagnosis, Prognosis and treatment for Behavioral Health and Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human ImmunodeficiencyVirus (HIV) infection for any date of service.

Signature of Patient or Authorized Person:	Date:
Relationship of Patient or Authorized Person:	
Print Name:	
Witness:	

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